VOICE OF THE DIABETIC

A SUPPORT AND INFORMATION NETWORK

The Diabetics Division of The National Federation of the Blind

Volume 5, No. 1 **Winter Edition** **Page 1**

Each and Every Day

by Charlotte Verduin

Charlotte Verduin is a long-term diabetic and an active member of the NFB. She says to think positive and "realize that no one is perfect. If you slip up once—you can get back on track right away."

"Gotta do an accu-check. . .gotta take my insulin. . .gotta eat my snack . . .gotta take my medicines. . .gotta get some exercise. . .gotta get some sleep. . ." Sometimes being a diabetic and living with the complications gets to be such a bore. Do you ever feel that way? I know I do. And I think coping with the temptation to become lax in our own care is an aspect of this chronic illness which is not much considered by doctors, family or friends. So I thought I'd put forward a few of my ideas on how I've learned to stay positive and on-track.

My diabetes developed at age 10. My parents explained the disease to me and explained the diet and medication and need for urine testing, the control method of that time. My mother from 1960 onwards ran a diabetic kitchen. The entire family ate good, plain food—no frying, gravies, sauces, and few sweets around our house. I was taught lots about good nutrition and diabetic care. But, being a child, I perceived one message in a "crooked" way, the way I wanted to hear it. It was: "YOU CAN LEAD A NORMAL LIFE if you follow your diet and a regulated lifestyle." My understanding of that sentence focused on being normal, doing exactly and anything that anybody else could do. And as a teen and young adult, that's much the way I lived, ignoring in large measure the "diet and regulated lifestyle." Because I believe I am not alone in this youthful perception of "it won't happen to me" and "I'm just like everyone else," I feel that it is very important to repeatedly and in emphatic ways impress upon young diabetics the necessity for routine and control. Emphasize the statement I heard in this manner: "You can lead a near-normal life IF YOU FOLLOW YOUR DIET AND A REGULATED LIFESTYLE." Teens and young adults need to be given the information about controlling diabetes, the support to do so, and guidance toward the realization that they are in charge, ultimately, of their own health. By getting these ideas across early, I believe facing the routine can be easier. It is basically a shift in responsibility for diabetic control from the parent-doctor team to the patient-doctor team as a child becomes more independent. And for those who are not children, there is a message here also. It is that you, the diabetic, must recognize and "take ownership" of your disease. The doctor is your expert guide, but the bottom line is, you eat, you take medicine, you know how you are feeling. And what you do is up to you.

Diabetes is a chronic illness. This means it does not have a cure. It is a lifelong, continuous care condition. At this point in time, unless you experiment with the pancreas transplant, you will always and forever be a diabetic. These words are easily understood intellectually. But the changes and daily "sacrifices" that equal good control are not as easily accomplished for everyone. Even those people for whom control is easy, I'd venture to say, have moments of

(Continued on page 2)

Voice of the Diabetic is a national publication of the Diabetics Division of the National Federation of the Blind. It is read by those interested in all aspects of blindness and diabetes. We show diabetics that they have options regardless of the ramifications they may have had. We have a positive philosophy and know that positive attitudes are contagious!

News items, address changes and other correspondence should be sent to the editor.

© 1989 Diabetics Division of the National Federation of the Blind.
ISSN 1041-8490

Inside This Issue

Each and Every Day by Charlotte Verduin 1

Positive Attitude Is Necessary If One Is to Handle Diabetes by Jill Schuetts 2

The National Federation of the Blind 4

Diabetes, Eye Disease and Laser Treatment (Photocoagulation) by Royanne R. Hollins 4

What Use Is the Long White Cane? 5

Do You Know a Blind Person? 6

Labels: More Than Meets the Eye by Nancy Cooper, R.N., C.D.E. 7

The Sodium Connection by Dorothy H. Stiefel 8

Food for Thought 9

Ask Dr. James by Ronald James, M.D. 10

My Working Transplants: Pancreas and Kidney by Susan J. Kucharzyk 10

Pancreas Transplants Enter a New Decade 10

National Senior Blind Committee Meeting Summary by Catherine H. Randall 12

Good News About Medicare Fairness by Bruce Fried 13

Fast Food Facts by Marion J. Franz, R.D., M.S. 14

Eat Your Milk by Claire C. Hammer, R.D. 16

Recipe Corner 17

What You Always Wanted to Know But Didn't Know Where to Ask (Resource List) 17

Leaders of the NFB Diabetics Division 18

Tidbits and Humor 19

National Federation of the Blind
811 Cherry St.
Suite 306
Columbia, MO 65201

Non-Profit Org.
U.S. Postage
PAID
Columbia, MO
Permit No. 360

Karen Mayry, President, 919 Main Street, Suite 15, Rapid City, SD 57701; Phone: (605) 348-8418

Ed Bryant, Vice-President, Editor, 811 Cherry Street, Suite 306, Columbia, MO 65201; Phone: (314) 875-8911

Each and Every Day

(Continued from page 1)

envy or even just wishing to be rid of their shots, medications or diets. So how do we make it past those temptations? I don't have the answer. But we each find what works. I think to myself "Do I want this piece of chocolate cake as much as I will want to live for one more day?" Sometimes the answer is yes, sometimes no. Or I think about the inevitability of advancing complications if I don't keep control, measured against the pleasure derived from the "bad" activity. Or I look at my 9-year-old daughter and remember that good control will mean a long life with her. Those are some of my personal motivators. We each need to find the things in our lives equally or more important than those "bad" behaviors of poor control and use them to keep temptations away. But also, realize that no one is perfect. If you slip up once—you can get back on track right away. Don't make excuses and rationalize that you blew it once, the whole day (week, month, year) is shot! Be strong. Try to remember that others are trying and succeeding. You can too.

My last comments on the subject of coping with the chronic, day-in, day-out aspects of diabetes are spiritual. I believe we each need to find our own philosophy of optimism to hold firm when things are bad. For myself, I've found it in reading French 17th and 18th century philosophy. This is certainly not the way for everyone. There are many self-help books available. I also derive great comfort from my Christian faith. With every health crisis, major or minor, my faith is strengthened as God cares for me. And last but not least, the fellowship, support and caring people of the NFB Diabetics Division, through information and by example, sustain me whenever I feel weak or alone, or that the routine is too, too boring. Use any help that you can get to "get you through this life." For many of us are in this daily battle together, and we can be well-controlled.

If you or a friend would like to remember the National Federation of the Blind in your will, you can do so by employing the following language:

"I give, devise, and bequeath unto National Federation of the Blind, 1800 Johnson Street, Baltimore, Maryland 21230, a District of Columbia nonprofit corporation, the sum of $_____ (or "_____ percent of my net estate" or "the following stocks and bonds: _____") to be used for its worthy purposes on behalf of blind persons."

Positive Attitude is Necessary if one is to Handle Diabetes

by Jill Schuetts

Having diabetes for 36 years is quite a challenge, but focusing on the positive things in life instead of becoming depressed could make all the difference in being able to successfully control and take care of the disease.

Karen Mayry, South Dakota president of the National Federation of the Blind, as well as the N.F.B. Diabetics Division president, spoke to a small group of diabetics and interested persons at the Sturgis Health Care Center's monthly clinic.

Mayry was diagnosed with diabetes when she was 11 years old. Not much was known about the disease at the time, and at first the doctors were not able to find out what was wrong with her. "My mother noticed I was crabby, tired, constantly thirsty, and I wet the bed. For an 11 year old to start wetting the bed is quite traumatic, so she took me to the doctor. They did several tests and couldn't find anything. They did a urinalysis at the end and that is where they found it. Just as my parents and I were walking out the door, they stopped us and said they figured it out."

At first the doctor told her mother to be strict. Later he said not to do anything differently than she had been, as Karen adapted to her routine exceptionally well. Mayry said, "My mom and dad gave me the insulin injections for awhile, then I thought, Why can't I do them? My younger brother helped me the first time I did it on my own. He squeezed my skin into a bump while I injected the needle. When the needle went in I was so surprised that I pulled it right back out, and had to start over!"

Disposable syringes were not available at the time, so she used a glass syringe which had to be boiled out daily.

While attending college, she said she consistently had high blood sugar readings. "I didn't want to be different. I didn't want to be on a special diet, and have everyone notice that I was different," she said. "Back then students didn't have the choices at cafeteria meals they do now. You got what they offered, and that was it."

Until then, none of her doctors had explained the possible long-term effects diabetes could have. A doctor now informed her that not watching her diet and having consistently high blood sugars could affect her eyesight and kidneys, and she could lose an appendage to amputation. She became more careful.

Karen Mayry, President, Diabetics Division, National Federation of the Blind, speaks to a group of persons interested in diabetes, telling them diabetics should focus "on the positive things in life, instead of becoming depressed. . .Attitude can make or break you. I enjoy life, and think about the positive."

Mayry said she then wanted to attend medical school or enter an education program, but the schools sounded hesitant, and she felt it was because of diabetes. After waiting quite a while, she wrote a letter to the education program saying she was just as qualified to enter the program as anyone who wasn't a diabetic. Her letter and the school's acceptance letter crossed in the mail, and she was accepted to the education program.

After her education, Mayry married. "One month to the day after our wedding, I lost the sight in my left eye due to a hemorrhage from diabetic retinopathy," she said. "One year later I could not read visually. I still had some vision, but I couldn't read. I continued to teach until we moved to South Dakota, where the law said I couldn't teach. We came to Rapid City where I worked at juvenile services until my kidneys started to fail."

The doctors said there was nothing they could do about the kidneys for now. They told her in about five years her kidneys would not be functional; it was eight years, she said. She feels it was due to the strict dietary and vitamin regimen she followed.

Mayry's younger brother gave her one of his kidneys, and she has had it for 12 years. "The day after surgery I was up and walking the halls," she said. "My brother was on his back and in a great deal of pain for quite a while. Needless to say, I was not one of his favorite people at that moment."

Being blind would seem to make injections and blood monitoring difficult. Mayry has a blood monitoring machine that beeps the numbers to her instead of making her read them. She uses a measured piece of corner molding to know how far to pull the plunger of the syringe and measure the correct amount of insulin. She showed other commercial devices which can be used for the same purpose.

Medical technology has recently developed laser treatment for eyes diagnosed with diabetic retinopathy. "Laser treatment is a retardant only," Mayry said. "It is a good tool, but it doesn't always mean you won't lose your sight anyway. Actually there is only a small percentage of diabetics today who will lose their sight, probably only 5 to 10 percent. Most of you will not, but you should be prepared just in case. The main things to remember are not to give up on your job, and don't go into a depression. Try to work with it and make the best of it.

"If your diabetic relative does lose their vision, help them to not grieve. Talk about it with them; help them work it out and move forward. To help avoid it or be prepared, all diabetics should see an ophthalmologist, not an optometrist, at least once a year," she continued.

Involving family members is also important. "Your family is involved whether they think they are or not," she explained. "They need to know as much about diabetes as you do, and they need to have a support system available for them.

"My husband stayed in a job 13 years longer than he wanted to for the simple reason he had good medical insurance with the company, and he didn't want to be without it. We were in Denver for a while and he was talking to a doctor about adopting a child. The doctor told him if he wanted to raise the child alone to go ahead and adopt. He said I would not live long enough to help raise the child. My husband kept this to himself for many years, and he shouldn't have had to do that. He quit talking about our adopting, but he never told me why."

Dealing with diabetes is a life-long dilemma, but it shouldn't rule everything the diabetic does, she said. "Sometimes we can get so hung up on the disease that we eat, drink, sleep and constantly think diabetes," she continued. "We need to remember to view it as only one part of ourselves, only one of our many aspects."

Focusing on following a diet and how it can make everyone, including non-diabetics, healthier is much better for the diabetic than thinking about the possible complications and becoming obsessed with the negative aspects of the disease. "Testing and keeping track of your blood sugars is exceedingly important," Mayry said. "However, some people may have complications no matter how good their control is, and some may have no complications no matter how bad their control is. You just have to do the best you can."

"A lot of how you are able to handle diabetes is in your attitude," Mayry continued. "Attitude can make or break you. I enjoy life, and think about the positive. However, my mother never did tell me that I became less crabby after I was diagnosed!"

(*Note:* This article was adapted from page 3, May 3, 1989, *Black Hills News*, Rapid City, SD.)

ACCENT Provides:

An Efficient Tool for the Visually Impaired.
Quality Speech with Vocabulary over 20,000 Words.
Five Models to Choose from for a Variety of Applications.
Supported by All Major Screen Reader Programs.

ACCENT MODELS

Accent-SA	Stand alone unit, RS-232C link to any computer ($940)
Accent-PC	Full length PC plug in card, on-board processor, no speed limit from PC ($745)
Accent-1200	Toshiba T1200 Laptop plug in card ($625)
Accent-1600	Toshiba T1600 Laptop plug in card ($625)
Accent-mini	Half length PC plug in card, runs on PC's CPU/Memory ($395)

SCREEN READER PROGRAMS SUPPORT ACCENT

Flipper (Omnichron, Dealer)	415-540-6455
Freedom-1 (Interface, Dealer)	503-665-0965
Jaws (Henter Joyce, Dealer)	800-969-5658
Keynote (HumanWare, Dealer)	916-652-7253
Screen Reader (IBM)	800-IBM-2133
Screen-Talk Pro (Computer Aids)	219-422-2424
Soft Vert (TSI, Dealer)	800-537-3961

OTHER U.S.DEALERS

Automagic (L.A. CA)	213-552-1412
LS&S (Northbrook, IL)	800-468-4789
Missing Link (Overland Park, KS)	913-642-4990
Universal (Columbus, OH)	614-486-0098

CANADIAN DEALERS

Betacom Systems	514-636-9267
Frontier Computing	416-489-6690
Intelligent Access Microware	519-679-4828
PC Systems, Inc.	604-380-9433

Aicom Corporation
2375 Zanker Road, Suite 205, San Jose, CA 95131
Tel: (408) 922-0855 Fax: (408) 922-0859

Diabetes, Eye Disease, and Laser Treatment (Photocoagulation)

by Royanne R. Hollins

Royanne R. Hollins, Insulin Pump Chairwoman, Diabetics Division, National Federation of the Blind, explains eye conditions caused by diabetes and their treatments.

Diabetics are 25 times more prone to blindness and partial loss of vision than non-diabetics. The risk of cataracts developing is four to six times greater in diabetics than in non-diabetics, and the opacity develops at an earlier age. There is also a two-fold greater risk of glaucoma in diabetics. One in 20 of all insulin-dependent diabetics becomes blind. About one in 15 non-insulin dependent diabetics develops retinopathy, which may cause partial loss of sight. Diabetics develop vascular lesions, predominantly microaneurysms, and increased vessel leakiness. The lesions usually do not affect vision and may be asymptomatic unless they involve the macula, the area of the retina responsible for central sharp vision.

Although many diseases threaten the retina, two afflictions cause more blindness than any other disorder of the eye — diabetic retinopathy and age-related macular degeneration. Diabetic retinopathy blinds more people between the ages of twenty and seventy-four than any other disease.

Diabetes attacks the vital capillary network of the retina. Diabetic retinopathy takes two forms, proliferative and non-proliferative. Many of the same symptoms occur in both types of the disease. In addition to the destruction of capillaries, tiny white spots appear on the retina where fats or fluids leak out of the damaged blood vessels. Other symptoms include patches of damaged nerve tissue called cotton-wool infarcts because of their woolly, white appearance and microscopic hemorrhages and microaneurysms.

Surgeons use lasers to destroy patches of tissue on parts of the retina. By sealing off some blood vessels to reduce the retina's demand for nutrients and oxygen, they hope to halt the progress of the disease. If retinopathy progresses to its proliferative stage, however, the outlook is worse. In some people who have suffered from diabetes since childhood, the insufficient blood supply to the retina apparently creates an insatiable demand for food and oxygen. New blood vessels supported by a net of fibrous tissue proliferate across the retina and the back of the vitreous. Injected into the blood stream, fluorescein dye clearly reveals the progress of the disease by outlining new retinal blood vessels and shows where there is an absence of circulation and leaking small vessels. The vitreous may pull on these new blood vessels, causing them to rupture and bleed into the vitreous cavity. Diabetic retinopathy sometimes blinds by obscuring vision with a dark cloud of blood-filled vitreous fluid. Photocoagulation with a laser can slow the advance of the disease and a vitrectomy often restores some useful vision. Proliferative diabetic retinopathy and its complications is occasionally an irreversible affliction. The cure for this eye disorder awaits the cure for diabetes.

Photocoagulation. That is a very big word. What does it mean? What is it all about?

Does it hurt? Some say no, some say yes and some say absolutely! Why is everyone different in what they experience? Why do some treatments hurt and others don't, even for the same person?

Some people have a very high tolerance for pain. Some people have a very low tolerance for pain. Some people want to be pampered as much as possible. Others are real martyrs and try to tough-it-out as much as possible and still succumb to the pain. Is it real "pain" such as the feeling of daggers in your eyes or instant migraine headache or is it a stinging of sorts? What kind of "pain" can be involved?

Pain is defined as a suffering of the body or mind. It can also be defined as a penalty or a punishment. Some people actually feel they are being punished for something (unbeknownst to them what) and feel guilty that the eye complications have occurred. Don't do this! It is not your fault you have diabetes. It is not your fault these complications have occurred. Do we know at this time or have any guarantee that strict control of keeping blood sugars normal would have made any difference in these complications? No. Therefore, you cannot look upon any form of pain as being a penalty or a punishment to you personally when you are battling complications of long-term diabetes.

An option that your retinal specialist always has when treating you with the laser is a nerve block. He will recommend this to anyone who is extremely apprehensive about the procedure about to take place. He will find this necessary for those who cannot tolerate the pain and/or procedure. The nerve block itself may cause a certain degree of discomfort. However, once it has taken affect, the entire laser treatment will pass without any further discomfort to the patient whatsoever. By the time the nerve block wears off several hours later, the normal discomforts from laser treatment will be wearing off at about the same time. Therefore, this is an option of choice for many.

"Pan retinal photocoagulation" or PRP is a technique used by your retinal specialist to treat your retina as a whole. He will pan back and forth across your retina in an orderly fashion in the hopes of catching all of the blood vessels that don't belong there. Pan retinal photocoagulation or scatter photocoagulation reduces the risk of blindness in patients with proliferative retinopathy. In this technique, photocoagulation is directed in a scatter pattern. Extensive scatter photocoagulation often decreases neovascularization on the optic disk and other areas and reduces the number of subsequent vitreous hemorrhages.

Proliferative disease, the more serious form of diabetic retinopathy, is characterized by neovascularization that leads to vitreous hemorrhage. This form is seen more frequently in insulin-dependent diabetics.

How did these vessels grow anyway? Something in the diabetes has caused them to grow. Your body probably stopped supplying the retina with an adequate blood supply and your body's response was to develop more vessels. These are new vessels that don't belong. This is called "neovascularization." Another big word!

Every diabetic patient should be examined regularly for the presence of retinopathy because this condition is usually asymptomatic at its most treatable stages. As you are being seen by your ophthalmologist on a regular basis, if you have any indication of this neovascularization, he will be watching these vessels very closely, for when they reach certain risk factors a recommendation for treatment will be made to treat them with the laser.

In the hands of a physician, the laser can be a healing light. Its intense beam can safely breach the cornea and lens and touch the innermost tissues of the eye. Some cases of proliferative and non-proliferative diabetic retinopathy and diabetes-induced glaucoma yield to laser treatment.

The laser session may be very intense. You must sit extremely still and quiet so your ophthalmologist can do his stuff. The last thing he wants you to do is to be wiggling around all over the place. Often his nurse will assist you in sitting still by holding the back of your head with gentle pressure, to keep your head in the brace of the slit lamp. That way it is not quite so intense on your body. Each treatment session will last from 15 to 30 minutes. Sitting perfectly still and trying not to jump out of your seat with every other laser zap tends to cause extreme tension and stress upon your body. Personally, I equate my feelings after an intense laser session to a "wet rag." I feel totally

The National Federation of the Blind

The National Federation of the Blind is the largest membership organization of blind people in the nation, having chapters in every state and approximately 50,000 individual members. It is the blind speaking for themselves. The National Federation of the Blind seeks to integrate the blind into society so that they are seen as normal, participating citizens—as people you would want to know, to hire, to work with, associate with in clubs and recreation.

We seek to show the public that we are just normal people who cannot see—not helpless and dependent, not blessed with special powers and gifts. We help the newly blinded learn that life can still be good. We show blind children that they can have a meaningful future. With proper training and skills, the blind can take a normal part in society—education, a job, a home, a family, normal recreation (camping, bowling, water skiing), and participation in community affairs.

We help blind persons find jobs—and the confidence to get and keep those jobs. Many willing, capable blind people have never had a job. Seventy percent of the blind are unemployed. Many of the rest are underemployed.

Our work is in the best interest of every American—our work to reduce blindness from a tragedy to a mere nuisance, our work to help the public accept the blind as normal people, our work to see that blindness does not mean isolation and dreadful loneliness.

How Can I Help?

You can inform yourself about blindness and help inform others. You can write for our literature, and you can get to know blind persons in your community. Blindness can happen to you or to one of your friends or to a member of your family. Don't wait for it to happen before doing something about it. You can begin today.

You can also help by making cash contributions to our organization or remembering the National Federation of the Blind in your will. The National Federation of the Blind is supported by public contributions. Donations are tax deductible and may be sent to:
Treasurer, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230.

3 Important Reasons
to Recommend the DIASCAN-SVM

$125 Consumer Rebate

- DIASCAN Test Strips allow "smearing" of blood sample without significantly affecting clinical result of test[1]
- DIASCAN-SVM is a simple, easy-to-use system that speaks your language
- Complete Starter Kit now available

[1]F. Falkowski "Effect of Technique Variations on Test Results of a Blood Glucose Monitoring System" AADE Meeting Presentations; August 1988

Complete Starter Kit (weighs 1.5 lbs.) includes Meter, Voice Module, 50 Test Strips, DIALET Lancing Device, Lancets, Control Solution, and Nylon Carry Case.

HDI • Home Diagnostics, Inc.

For product information, sample cassette tape, and nearest distributor please call 1-800-DIASCAN; in NJ 1-201-542-7788

DIASCAN is a trademark of Home Diagnostics, Inc.

drained, as if I cannot do anything the rest of the day. I never drive after a laser session. I kind of roll into my car with my driver, go home, go to bed and stay there until the next day.

I am the type of person who does not like to take medications other than the required insulin. Therefore, I do not ask for any pain medications. However, I am sure if I were to ask, my ophthalmologist would be happy to oblige to make this easier on my system. Since I work full-time I choose Friday afternoons for my appointments with my retinal specialist, as I never know ahead of time whether or not he will be doing laser that day. That way I can go home and go to bed and take all weekend to recuperate, if necessary, prior to going back to work on Monday.

Keep in mind that if you are told you need some laser treatments, you are always entitled to a second opinion if you feel one is necessary. A second opinion has helped me out in several matters that I have had to deal with. Those second opinions have also instilled in me an even greater trust in the health care team I have developed over the years and verified their competence to me.

Ask questions. Have your physician explain the technique he intends to use. Ask him how long the treatment session will be. Ask him if it will be painful. He may have some indication from your past history as to whether it is going to be painful to you. Make sure that all of your questions are answered before pursuing any treatments. It is probably the best thing you could be doing for your eyesight at that time and you certainly do not want to miss out on the opportunity to maintain the vision you have or even to improve your vision in some way.

Some people get great results from laser treatments. Others continue to deteriorate no matter what. However, we need to give ourselves all the chances we possibly can, whether laser treatments for our eyes, regular home blood glucose monitoring, taking care of our feet with daily inspections, being aware of new and better treatments for the control of diabetes (such as insulin pumps for intensive therapy) or following our diet and exercise plans as closely as possible. We need all the extra help we can get; this gives us the best control. If your ophthalmologist suggests laser at any point, I highly encourage you to do so but to take into consideration as much of the above as possible. Mainly, be educated and get your questions answered ahead of time.

Ophthalmological surgery has made tremendous strides during the last few decades. Vitreous surgery is being used to treat unresolved vitreous hemorrhages and for traction retinal detachment. This surgery, which has significant associated risks, can restore useful vision in some individuals who might otherwise be blind. When the eye's normal ability to absorb blood from the vitreous cannot clear vision, surgeons can sometimes attempt a vitrectomy in an effort to save sight. As the vitreous attaches in some places to the retina, surgeons attempting a vitrectomy must take great care to keep from damaging the retina's delicate tissues or rupturing still more blood vessels.

In essence, we are in very good hands today. We all benefit from the marvelous discoveries and new therapies coming our way. However, as stated above, the cure for retinopathy awaits a cure for diabetes.

If, in your treatment, your physician says laser treatments are needed, I wish you the best ... happy lasering!

What Use is the Long White Cane?

(*Note:* This article appeared Spring 1989 in **The Mini-Monitor,** the newsletter of the National Federation of the Blind of Florida. These are excerpts from "Cane Travel" by Sharon Duffy, Mobility Instructor for the New Mexico Commission for the Blind Orientation Center. Copyright 1987.)

Cane travel is one of the most valuable skills a blind person can attain. It not only means independence for the individual, but is more often the means of acceptance of blindness than any other skill.

1) A blind person who uses a cane is not only making a statement to others that he is blind, but, more importantly, is acknowledging his own blindness. In dealing with the challenges that blindness brings, the first step must be this acceptance of blindness, and then the ability to look at each problem unemotionally and logically to work out its solution.

2) It is respectable to be blind. It is respectable to use a cane, and it is normal for blind persons to use canes.

3) Why is the denial of blindness so prevalent? Throughout time, blindness has been portrayed as helplessness, and today it continues to get bad press via commercials, movies and literature. Most blind people recognize that they do not fit the negative stereotypes presented. Therefore, many blind individuals' reaction is to deny that they are blind. Pride in ourselves as human beings and acceptance of what we are is the real solution.

4) We should take our white canes with us wherever we go. It is important in identifying ourselves as blind persons in terms of public awareness. Identifying oneself as blind can reduce the number of uncomfortable situations which would arise without it. The blind person who asks where something is, something in plain sight, spares himself and the sighted person embarrassment. Since the incidence of blindness is so low, a person probably would not immediately conceive that the individual asking the question is blind.

5) Many blind people mistakenly believe that they appear more "normal" if they don't carry a cane. The fact is that the public may not recognize that a person is blind, but does realize that there is something

(Continued on page 6)

Do You Know A Blind Person?

DO YOU KNOW A BLIND PERSON?

Do you know a blind person who needs help or information? Perhaps he or she is newly-blinded and having trouble adjusting to the loss of sight. Maybe he or she does not know about all the services that are available, such as Social Security benefits, rehabilitation, or library services.

Whoever it is — a newly-blinded man or woman, a senior citizen with failing eyesight, a blind child or infant — we (the National Federation of the Blind) would like to try to help.

About 500,000 people in the U.S. are blind, and each year 50,000 more will become blind. Studies have shown that only cancer is feared more than blindness. However, blindness does not need to be the tragedy which it is generally thought to be. With proper training, knowledge, and opportunities blind people can be productive, first-class citizens.

But first the blind individual must know *where and how* to get the training and services he or she needs. We —you and the National Federation of the Blind — can work together to find and provide necessary information to the blind in our communities.

Here are some of the services available to the blind in our communities. For more specific information about any of these services, please contact us.

LIBRARY

Our state, like every state, has free library services for the legally blind. Books and magazines are available (on loan and free of charge) in braille, large print, and on cassette and records. Special cassette machines and record players to use in listening to the taped or recorded reading matter are also loaned without cost to blind library users. For details about where and how to apply for services in your area you may contact us or your local library.

SOCIAL SECURITY BENEFITS

Social Security Disability Insurance (SSDI): Legally blind persons who have paid into the Social Security system may be eligible for SSDI under the special rules which apply to the blind. Legally blind senior citizens considering early retirement should first learn if they might qualify for more benefits under SSDI. *Supplemental Security Income (SSI):* Blind persons who have little or no regular income or savings may qualify for monthly payments under the SSI program. Again, there are special rules which apply only to the blind. Contact your local Social Security office for information and applications. We also encourage blind persons to contact us if they have any problems understanding the regulations, feel they have been unjustly denied benefits, or have other problems about which we may be able to provide information and guidance.

REHABILITATION

Every state, including this one, has a public rehabilitation or vocational rehabilitation agency which provides training, counseling, and employment placement services to the blind. Sometimes the service is provided directly, and sometimes it is contracted out to private rehabilitation facilities. Some funds through the rehabilitation agency are usually available to students for college education or other post-secondary training. Contact us for information about where to apply for services in your area.

EMPLOYMENT

Blind persons may use the regular public and private employment agencies just like anyone else. However because of widespread misconceptions about the abilities of the blind, special employment services are extremely helpful. Job Opportunities for the Blind (JOB) is a special nationwide job listing and referral service sponsored by the National Federation of the Blind in partnership with the U.S. Department of Labor. JOB uses recorded materials, computers and volunteers to help blind people find competitive employment. There is no charge for this service. To apply for services write to: JOB, 1800 Johnson Street, Baltimore, MD 21230; or call (toll-free) (800) 638-7518.

SCHOLARSHIPS

Blind students can take advantage of the same scholarship programs that are available to sighted students and should be encouraged to do so. However, there are also scholarships which are only available to blind students. The National Federation of the Blind, for example, awards over $50,000 a year in scholarships to worthy blind students. Contact us for further details about these and other special scholarships for the blind.

CIVIL RIGHTS

There are federal and state laws and regulations which protect the civil rights of the blind in such areas as employment, education, housing, insurance, public transportation, and public facilities. If you know of someone who thinks he or she has been unjustly treated or discriminated against just because of blindness, please contact us. We will try to help.

PRODUCTS AND AIDS

Technology has made many useful products available to the blind. Some aids make daily life easier (example, the braille watch) while others have opened up more employment opportunities for the blind (example, talking computers). Contact us for more information about local and national resources regarding products for the blind.

FREE READING MATTER MAIL PRIVILEGE

Recorded, braille, and large print reading matter (including library books and magazines) may be mailed to and from blind persons free of charge if "Free Matter for the Blind" is written or stamped on the envelope or package. Braille watches, white canes, and other special appliances for the blind are included in this privilege. We will be happy to answer questions about the Free Reading Matter mail privilege.

PUBLICATIONS

The *Braille Monitor* is a monthly magazine published by the National Federation of the Blind in braille, in print, in cassette, and on disc. The *Braille Monitor* keeps blind and interested sighted readers informed about issues, news, and events which have special significance to the blind. A free subscription is available by writing to: *Braille Monitor,* National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230 (be sure to designate whether the *Monitor* is desired in print, braille, cassette or on disc.) For information about local newsletters of special interest to the blind contact us.

EDUCATION OF BLIND CHILDREN

The passage of Public Law 94-142, the Education of All Handicapped Children Act, established certain rights and protections for blind children and their parents. Blind children are now entitled to a free public education in the "least restrictive environment," and parents have the right to help plan their child's educational program. Contact us for more information about the education of blind children, parent organizations, newsletters, etc. Also, the National Federation of the Blind publishes a magazine for parents of blind children. This publication provides information and insights into all aspects of raising blind children from infancy to adulthood. A free subscription is available to parents or other interested persons by writing to: Future Reflections, National Federation of the Blind, Free Subscription Request, 1800 Johnson Street, Baltimore, MD 21230.

For information or assistance concerning any problem dealing with blindness contact your local chapter or state affiliate of the National Federation of the Blind or: National Federation of the Blind, 1800 Johnson Street, Baltimore, Maryland 21230, (301) 659-9314.

COURTESY RULES OF BLINDNESS

When you meet me don't be ill at ease. It will help both of us if you remember these simple points of courtesy.

1. I'm an ordinary person, just blind. You don't need to raise your voice or address me as if I were a child. Don't ask my spouse what I want —"Cream in the coffee?" — ask me.
2. If I am walking with you, don't grab my arm; let me take yours. I'll keep a half-step behind, to anticipate curbs and steps.
3. I want to know who's in the room with me. Speak when you enter. Introduce me to the others. *Include children,* and tell me if there's a cat or dog. Guide my hand to a chair.
4. The door to a room, cabinet, or to a car left partially open is a hazard to me.
5. At dinner I will not have trouble with ordinary table skills.
6. Don't avoid words like "see." I use them, too. I'm always glad to see you.
7. I don't want pity. But don't talk about the "wonderful compensations" of blindness. My sense of smell, touch or hearing did not improve when I became blind. I rely on them more and, therefore, may get more information through those senses than you do — that's all.
8. If I'm your houseguest, show me the bathroom, closet, dresser, window — the light switch, too. I like to know whether the lights are on.
9. I'll discuss blindness with you if you're curious, but it's an old story to me. I have as many other interests as you do.
10. Don't think of me as just a blind person. I'm just a person who happens to be blind.

In all 50 states, the law requires drivers to yield the right of way when they see my extended white cane. Only the blind may carry white canes. You see more blind persons today walking alone. Not because there are more of us, but because we have learned to make our own way.

What Use is the Long White Cane?

(Continued from page 5)

different — mental retardation, drunkenness, illiteracy, to name a few. Ultimately, it is more comfortable for blind people to identify themselves as blind, allaying the confusion that results from the mis-identification that would otherwise inevitably occur.

6) Self-confidence is the goal of cane travel. It can be achieved through promotion of the respectability of blindness, learning good technical skills and challenging ourselves to do what we did not believe we could do. Do whatever it takes to attain this end.

CHALLENGE YOURSELF TO ACHIEVE INDEPENDENCE.

Labels: More Than Meets the Eye

by Nancy Cooper, R.N., C.D.E.

Are you confused about what to buy when you go grocery shopping? Do you know what it means when a food product is labeled *reduced calorie, no cholesterol, low sodium, or diet?*

More and more manufacturers are featuring nutrition messages on their products in the form of food labels, which include descriptive terms, ingredient lists, and nutrition information. The key is knowing how to interpret these messages to help you make smart food choices that fit the nutritional recommendations for good health.

Food labels can help you decide which foods are appropriate for your diet. Ingredients must be listed in descending order by weight (the first ingredient listed is present in the largest amount and the last ingredient listed is present in the smallest amount). Also, if a manufacturer makes a nutrition or health claim about a food, or if nutrients are added, a complete nutrition label must be present, although many manufacturers volunteer nutrition information on products when it is not mandatory. To understand a food label, remember these guidelines:

- Read the descriptive terms on the label, such as *reduced calorie, low salt, or diet.*
- Read the ingredient list so you can decide whether you want to use the food.
- Study the nutrition label so you know how many calories and which nutrients, such as carbohydrates, protein, and fat, the food contains. Use this information to convert a serving of the food into exchanges for a meal plan.

Terms on Labels

Did you know that *natural* products can contain artificial colors, flavors, or preservatives and foods with *no salt added* can still have sodium? Did you know that products labeled *sugar free* may contain other sweeteners and have as many calories as their sugared counterparts?

Some terms on food labels are regulated by the Food and Drug Administration (FDA). Labeling of meat, poultry, and egg products is regulated by the U.S. Department of Agriculture (USDA). However, many terms do not have regulated definitions, and they can be misleading.

For example, the word *light* on a food product other than meat or poultry can mean anything from lighter color, texture, or taste to less sodium, calories, or fat.

Unsalted, no salt added, or *without added salt* all mean that no salt has been added to food that is normally processed with salt. It doesn't mean the food is low in sodium! There may be other ingredients present besides salt that contain sodium.

If a food is labeled *natural,* there is no guarantee of purity or safety unless it is a meat or poultry product. On meat and poultry, it means there are no added artificial flavors, colors, or preservatives. It has no standard meaning on any other food items.

When you see *no preservatives* on a label, the intent is to make the food appear healthier or more natural than foods that contain preservatives. But, food made without preservatives can contain other common food additives such as sweeteners, colors, flavorings, emulsifiers, thickeners, and leavening agents. Therefore, *no preservatives* does not mean no additives.

Ingredient Lists

It is important to study the ingredient list for things you may want to limit or avoid, especially types of fat. Saturated fat raises blood cholesterol levels, thereby increasing the risk for heart disease. It comes from animal products; palm kernel and coconut oil (found in many processed commercial food products); cocoa butter (found in chocolate); solid shortenings; and dairy products containing butterfat. Unsaturated fat, on the other hand, tends to lower blood cholesterol levels. It is found in vegetable products such as corn, cottonseed, safflower, sunflower, sesame, soybean, olive, avocado, and peanut oils. Saturated and total fat intake should be limited to less than 30 percent of daily calories.

If you have been told to limit sodium in your diet, watch for ingredients that contain salt or sodium chloride, monosodium glutamate, broth or brine, bouillon cubes or granules, soy sauce, and baking soda.

If you need to restrict sugar in your diet, watch for sucrose (white table sugar) and other words ending in "ose." *Nutritive sweeteners* are those that contain calories (invert sugar, corn syrup, honey, molasses, maple

(Continued on page 8)

If you are blind, visually impaired, or dyslexic, the new, lightweight Personal Reader is one of the best friends you'll ever have.

- It's always around when you want confidential access to printed materials.
- It reads single sheets or bound documents by instantly turning the printed word into DECtalk™ synthetic speech.
- It's the only optical scanner using intelligent character recognition.
- It's reliable, portable and available at a cost low enough for an individual to purchase.
- It goes with you to the office or library any time of the day or night.
- It's compatible with word processing, communications and Braille conversion software packages.
- It interfaces easily with other computer hardware creating an interactive workstation for reading, writing and storing information.
- It's a valuable on-the-spot teacher for students of all ages.

*DECtalk is a trademark of Digital Equipment Corporation

KURZWEIL COMPUTER PRODUCTS A Xerox Company

XEROX/KURZWEIL PERSONAL READER
An optical scanner that turns print into speech.

Personal Reader Department 185 Albany Street Cambridge, MA 02139
(800) 343-0311 In MA (617) 864-4700 FAX (617) 864-4186 TX 951246

Labels

(Continued from page 7)

syrup, brown sugar, and sorbitol). *Non-nutritive sweeteners* contain few or no calories (saccharin and aspartame, or Equal® or NutraSweet®). Based on scientific study, the FDA has approved the use of saccharin and aspartame.

Some products, called standardized foods, must contain certain mandatory ingredients that don't need to be listed on the label. These "standards of identity," set by the FDA, cover all foods called by a particular name (e.g., "catsup" or "mayonnaise") as well as foods like milk, cheese, bread, flour, and macaroni. However, some manufacturers voluntarily list ingredients on standardized foods because consumers find that helpful.

Nutrition Information

Nutrition information follows a standard format and is given on a per-serving basis. The label must state the size of a serving in common household units and the number of servings in the container. It also must state the number of calories; grams of protein, carbohydrate, and fat; milligrams of sodium; and percentages of several important vitamins and minerals per serving. Milligrams of cholesterol and grams of saturated and unsaturated fat may also be listed.

Information on a nutrition label can be used to determine the percentage of calories from the three major nutrients in food. The amount of protein, carbohydrate, and fat in a serving of food is expressed in grams. A gram is a metric unit of weight, and there are about 28 grams in one ounce. One gram of protein or carbohydrate contains 4 calories, while one gram of fat contains 9 calories. Using these figures, you can calculate the calories that come from each nutrient.

Suppose for example, that the following appears on the label of a "cheese spread":

Nutrition Information Per Serving
Serving Size: 1 oz
Servings per container: 4
Calories:100
Protein: 3 grams
Carbohydrate: 2 grams
Fat: 9 grams

In this example, one ounce of cheese spread contains 3 grams of protein. Three grams times 4 calories per gram equals 12 calories from protein. Similarly, 2 grams of carbohydrate at 4 calories per gram equals 8 calories from carbohydrate; and 9 grams of fat at 9 calories per gram equals 81 calories from fat or approximately 80% of the total calories.

As you can see, fat is the primary source of calories in this cheese spread. Since it is important to reduce dietary fat intake, it is helpful to know how to calculate the percentage of calories from fat in food products.

Now that you can define terms found on a label, analyze ingredient lists, and evaluate nutrition information, how can you translate this information into a healthy diet? Remember, "variety is the spice of life." Your body needs about 40 different nutrients for good health, and no single food provides all of them. Therefore, a variety of foods in your diet is a necessity.

Americans tend to assume food must be high in fat, sugar, salt, and calories to taste good. We believe sacrificing any of these ingredients will automatically reduce the flavor and pleasure we get from food. Try not to close your mind to healthier food choices! By making slow, gradual changes in your eating habits, you can make a positive and long-lasting difference in your health!

(Labels: More Than Meets the Eye, by Nancy Cooper, RN, CDE appeared in *Living Well with Diabetes,* Summer 1989, pages 14-15. Reprinted with permission from the International Diabetes Center.)

The Sodium Connection

by Dorothy H. Stiefel

The proverbial bandwagon is teeming with folks touting the negative side of dietary salt intake as the media continues to focus on the dangers of ingesting too much sodium. While most health and medical professionals have taken a unified stand against what they claim is an alarming increase in sodium ingestion by America's food consumers, some of the literature suggests an over-reaction to what is being called "salt abuse." How much do we really know about this basic mineral which is found in all living things?

In *Salt: The Mysterious Necessity,* man is said to have his own "internal salty sea" which has sustained him all his life since the beginning of time. Salt, also known as sodium chloride, has been extolled throughout the ages for its diversity of uses and benefits — an intrinsic component of life with an unblemished "track record." But today consumers are being cautioned to read food labels carefully and to find other ways to season what they eat. Some reports suggest discarding the salt shaker altogether. But the grim realities of what too much sodium can do to the human body run subtly and deep. Most people, trusting that the largest industry in this country would be reliably monitored, would never have thought they would have to read labels in order to avoid health problems. Now that it has become a necessity, small print often makes it difficult to read, even for the fully sighted. In addition, far too many cartons carry confusing information, making proper interpretation virtually impossible. How would you know which of the numerous sodium-based ingredients to avoid and how much salt is too much?

The American Heart Association (AHA) recently updated their pamphlet which addresses such questions. *Salt, Sodium and Blood Pressure: Piecing Together the Puzzle* states that "the average American consumes 6 to 18 grams of salt daily," an exceedingly high amount by any standard. (Food labels usually list sodium contents in milligrams (mg); 1,000 of these make a gram (gm).) Man actually needs only half a gram (500 milligrams) of salt daily. Much of this is readily obtainable through our drinking water and in our natural fresh grown vegetables.

At the present time, the recommended level of daily sodium intake is controversial for the general population. Some physicians don't feel their patients should "hold the salt," but most concede that two to three gms. of sodium is a normal intake range for the average healthy food consumer. However, a much lower consumption is recommended for those with certain health problems --persons with hypertension and heart disease, as well as for those who suffer from kidney and liver disease or dysfunction. The kidneys act as a specialized filtering system in keeping the body's salt balance regulated at all times. But the kidneys simply are not equipped to handle the burden of a lifetime of filtering excessive sodium without a realistic threat of kidney damage. Unfortunately, the public knows even less about another "connection" to the sodium factor — edema from fluid retention. It can and does cause vision problems, which, if left unchecked, can lead to blindness.

I was confronted by this fact in a very personal way — in the doctor's office when Dr. Rex Hawkins, a retinal and vitreous specialist in Houston, Texas, handed me his booklet, *Salt Control.* After giving me a diagnosis for my current eye problem, he gave me some interesting information and guidance as he counseled me about having cystoid macular edema.

In his booklet, Dr. Hawkins states that a limited salt diet will "decrease the tendency for fluid to leak from retinal capillaries." I found this to be a significant statement. After two months of voluntarily cutting my salt intake by 60 to 75 percent, my visual acuity increased. I was especially elated over the double reward of a simultaneous decrease in my blood pressure. It was the very first time an ophthalmologist had been instrumental in helping me improve my general health as well as providing good eye care.

Armed now with basic facts and a persistent curiosity for the cause and effect phenomena of a serious health issue, I began to research this subject more thoroughly. How could something so rampant have affected so many people without their knowledge and understanding? According to the general literature, several factors over the last two decades have greatly influenced the dramatic rise in our society's high sodium ingestion. The emergence of the fast-food industry about 20 years ago became a boon for families eating on the run. Then, as more and more women joined the work force, home cooking was virtually abandoned for the "take home" variety. Processed foods of every sort, saturated with sodium based preservatives and additives, began filling supermarket shelves and frozen food compartments. Canned goods, quick-mix boxed meals, and the all-time favorite, T.V. dinners (notoriously infiltrated with 10 to 20 additives) — all these await the weekend shopper looking for fast ways to feed a hungry family.

So, how can one stay healthy without having to stop eating? Moderation should be the general rule of thumb, unless, of course, you are one of those people who are "salt sensitive" or you fall into one of the health categories mentioned above. Otherwise, obtaining good information and applying common sense to your eating habits will help you keep your sodium intake level within reason. A few pointers follow:

1. Contact the AHA in your area and request their newest pamphlet and other information on sodium. The pamphlet lists comparative menus and you'll learn quickly which foods are highly saturated and which contain low amounts of sodium without giving up good taste.

2. Whenever possible, eat fresh foods, such as fruit, vegetables, lean beef, fish and poultry. If you have to use canned foods, use the "half the salt" brand. Avoid products which fail to list their ingredients. (The symbol NA will identify sodium content.)

3. Request information about additives used in meal and snack foods prepared in your favorite fast-food restaurant. The FDA has required that consumers must be given these facts.

4. Check with your physician if you think you need more information about how your dietary salt intake may be adversely affecting your health. Always check with your doctor before attempting any large scale change in your eating habits.

(*Note:* This article appeared Spring 1989 in *Dialogue* Magazine. Reprinted with permission from the author.)

COMING SOON FROM
PENNY SAVER AND AMES

THE FIRST BLOOD GLUCOSE METER UNDER $50.00

THE GLUCOMETER® 3 Diabetes Care System

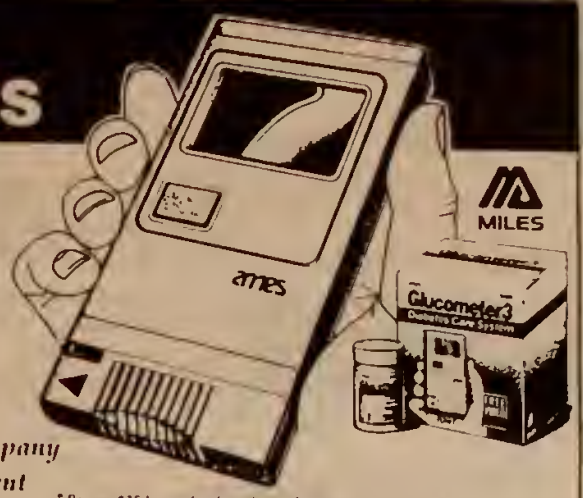
AVAILABLE FEBRUARY 1, 1990

SPECIAL 44.95
LESS MFG. TRADE-IN *-35.00
FINAL COST AFTER TRADE-IN $9.95

Offer good February 1 — May 31, 1990.

- Just the right size.
- Easy to use.
- Highly accurate.

Call your insurance company to check on reimbursement for a Blood Glucose Meter



* Receive $35 by mail with trade in of competitive meter (must not be a Miles Inc product except the Ames™ GLUCOMETER Reflectance Photometer)

SPECIALS

LANCET SPECIAL 200/BOX $7.95
Generic #ULH3300

ALCOHOL SWABS 200/BOX $1.99
Generic #MZMDS090730

DIGITAL BLOOD PRESSURE MONITOR #ME85
Reg. $78.00 SPECIAL $69.00

SAVE ON PRESCRIPTIONS!!
Prices quoted on request.

CALL TOLL FREE FOR A FREE CATALOG AND TO CHECK OUR LOW PRICES ON HOME BLOOD GLUCOSE MONITORS
12/89

Penny Saver Medical Supply
1851 W. 52ND AVENUE, DENVER, COLORADO 80221
No Shipping Or Handling Charge On Orders Over $50.00
Money Back Guarantee

NATIONAL WATS: 1-800-525-7688
COLORADO WATS: 1-800-332-7697
METRO DENVER AREA: 455-5501
OUR 40TH YEAR IN BUSINESS

Food for Thought

CLARIFYING MISCONCEPTIONS ABOUT DIABETIC DIETS

Since it is estimated that more than 10 million Americans have diabetes mellitus, more commonly known as diabetes, you undoubtedly have a friend or relative who has this chronic disease. Indeed, unknowingly or knowingly, you may already have diabetes yourself or you may develop the disease in the course of your lifetime. But as common as it is, mystery and misconceptions cloud most people's thinking about the disease. Does what you eat determine whether you'll get diabetes? Once you have it, what can you—or should you—eat? Is there a dietary route you can follow to prevent diabetes? For these and other often-asked questions, we sought out Beverly Halford, MPH, Director of Nutrition, Joslin Diabetes Center, in Boston, to provide practical answers. Ms. Halford is a registered dietitian who has extensive clinical experience with people with diabetes.

Q: *Diet is said to be the cornerstone for treating all forms of diabetes. Why is it so important?*
A: Speaking broadly, diet is important because diabetes is a derangement in the way the body metabolizes three major nutrients. Most people think that only carbohydrate metabolism is involved, but the body's handling of fat and protein is also a factor. The majority of people with Type II—that is, adult-onset—diabetes are overweight and can be controlled with diet alone, especially if they lose weight. And diet may help prevent some common complications of diabetes.

Q: *What would you say are the newest developments in diet and diabetes, particularly for the Type II form, in the last five years?*
A: The most important development is our growing understanding of how critical it is for people with Type II diabetes to lose weight. They often produce enough or even too much insulin, but their bodies are unable to use it. When they lose weight, their own insulin becomes adequate to meet their needs.

Q: *Turning to sweeteners—which ones are best for people with diabetes?*
A: At Joslin, we have no problem with people using moderate amounts of saccharin and aspartame. But no one has ever demonstrated that using sweeteners helps people lose weight. They're basically helpful for those with a sweet tooth. We allow people with diabetes to use powdered fructose, but only if they are well controlled and can afford the calories. However, individuals should consult their physicians and dietitians about its use. In general, we encourage patients to eat more fruits—the "natural sweets."

Q: *Are alcoholic beverages taboo for the person with diabetes?*
A: Usually, no. Again, the big concern for Type II diabetes is calories. We can work small amounts of alcoholic drinks into the diet based on calorie content. But people with Type I—also called juvenile-onset diabetes—have to be careful because if they drink without eating their blood glucose can run too low.

Q: *Are there any special concerns about salt and caffeine for the person with diabetes?*
A: The concerns are no different than for the population in general. The rule is moderation in all things. It is wise for all of us to cut back on salt, but people with diabetes don't need low-salt diets unless they also have hypertension. Years ago, it was thought that caffeine might raise blood glucose, but that has not been proved.

Q: *Do people with diabetes have any special vitamin or mineral needs?*
A: Not that we know of. If they eat the well-balanced diet we're discussing, their needs should be met without any supplements.

(*Note:* This article appeared July/August 1988 in the *Good Food and Health* newsletter, a division of Encal, Inc. Reprinted with permission.)

Don't Let Insurance Stop You

Insurance is no barrier to hiring the blind. Misinformation about insurance coverage for blind workers deprives many businesses of the contributions blind workers could make. JOB (Job Opportunities for the Blind) is a joint project of the NFB and the U.S. Dept. of Labor, and wants you to know the facts about insurance and the blind.

Insurance rates will NOT go up if you hire a blind person. Accident insurance rates are based on the actual experience of a company. Individual characteristics of workers are not considered when determining your insurance rates.

Blind workers are not a greater insurance risk. Every study ever done indicates that the safety records of blind employees equal or exceed those of sighted workers.

You may not be charged higher workman's compensation if you hire a blind worker. Workers who are already blind when they are hired cannot collect workman's compensation based on blindness. Likewise, they cannot be denied benefits because of their blindness.

Ask Dr. James

by Ronald James, M.D.

Ronald James, M.D., long-term insulin-dependent diabetic, directs Midwest Diabetes Treatment and Education Center, Columbia, MO. Dr. James is also the Medical Director of the Central Missouri Diabetic Children's Camp, Inc.

(**Note:** If you have any questions for Dr. James, please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.)

Should I call my doctor any time I find the presence of ketones or acetone in my urine?

That will depend upon your particular situation and what your doctor has instructed you to do. Ketones are produced and excreted into the urine when one's body burns fat as a source of energy. This can occur with food restriction as during fasting or starvation, during an illness that interferes with eating, during use of a reducing diet or after an overnight fast. It can occur in the diabetic who has so little insulin he cannot use the carbohydrate and protein in his diet and changes to burning fat instead. In the latter case, the blood sugar will be elevated and ketones in the urine will be an indication of a serious problem. Some doctors may have instructed their patients to take extra insulin when this occurs. Others may wish to be called. Follow your doctor's directions. If you are uncertain what to do, call him.

I take insulin and am wondering if it would be possible for me to start using tablets for helping to control my diabetes?

That depends upon your particular condition. If you have Type I insulin dependent diabetes, the tablets will not work and you must take insulin to stay alive. For Type II non-insulin dependent diabetics, in some cases it may be possible to switch from taking insulin to taking the tablets, particularly if the insulin doses are low. Some physicians like to use a combination of the tablets and insulin. There is a difference of opinion among physicians regarding whether it is good to use the tablets. I tend to prefer insulin in most cases and therefore seldom prescribe the tablets. You should discuss this with your personal physician since he knows you best and will know what is the best treatment for you.

I know there is much diabetic research going on and want to know if there is a date when researchers feel that diabetes will be halted and people will not develop it any more?

Physicians and scientists have been attempting to cure diabetes in man by transplantation of pancreatic tissue for over 50 years. Because of the problem of rejection of the transplanted tissue and the serious side effects of the drugs required to prevent rejection, there is not yet a practical cure for diabetes. Nevertheless much work is being done around the world in this field in hopes of some day finding a cure.

Another approach to halting the diabetes problem is to find a method to prevent its onset. Investigators are attempting to find a diabetes marker, that is, some test which will accurately predict who will develop the disease. Then the hope would be to find a method to prevent its onset in the susceptible individuals. No date can be set at this time as to when a practical cure or a method of preventing diabetes will occur.

Pancreas Transplants Enter a New Decade

Procedure Promises Benefits for a Group of Patients

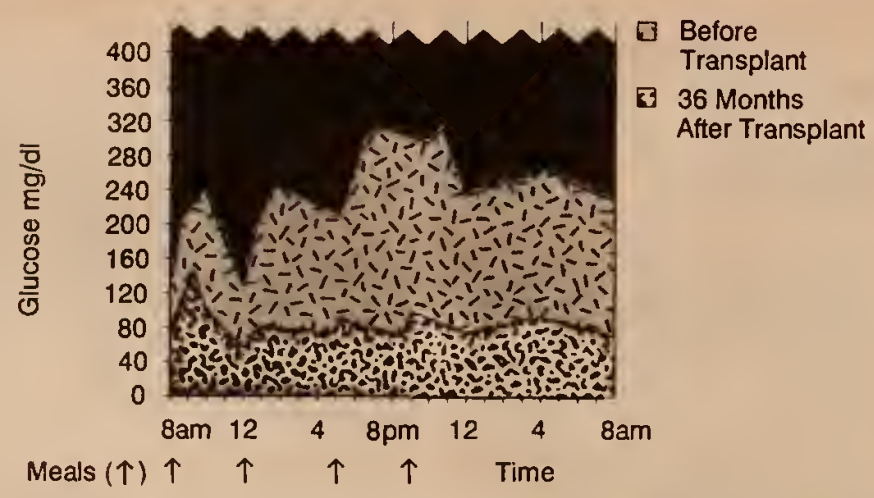
As millions of people around the globe wait for the day when diabetes is cured, doctors and researchers are seeking effective ways of arresting the relentless progress of the disease. No approach is as dramatic or as basic as the replacement of a non-insulin producing pancreas with a new, healthy organ.

The principle is simple: obtain a pancreas (or pancreas segment) from a donor and hook it up inside the body of a person with diabetes—insulin is secreted into the bloodstream precisely when needed and glucose levels are restored to normal.

The practice, however, is much more complicated. Not only is it a challenge to obtain and preserve healthy pancreases for transplantation, it has required a major feat of engineering to develop effective and efficient ways of placing one within the body. Despite these obstacles there is much to be enthusiastic about: pancreases are now able to be preserved and shipped around the country; new surgical techniques allow doctors to attach the organ in a location allowing its health to be monitored. The patient's own pancreas does not have to be removed, only the new one added.

As a result of this progress, pancreas transplants are being performed with an increasing amount of success every year. More than 1500 have been performed worldwide and the success rate varies between 40 and 80 percent. New ground is being broken that promises to bring the potential benefits to an even wider group of patients. Traditionally, such operations are done on diabetes patients who have had or are having a kidney transplant. However, at the University of Minnesota pancreas transplants are also being done on patients who do not need kidney transplants. These potential recipients must have at least one diabetic complication that is determined to be as severe as (or is progressing to a stage that would be more severe than) the risks of the operation. They may have marked deterioration in nerve function, eyesight or kidney function, but none have end stage problems. This is controversial, but very promising.

Why then have so few pancreatic



BLOOD SUGAR LEVELS BEFORE AND AFTER TRANSPLANT Blood sugar (glucose) levels before and one and two hours after each meal during two typical days in the life of a diabetic patient, one before and 36 months after a successful pancreas transplant at the University of Minnesota Hospital. Before the transplant, all of the values were within the normal range (70-160 mg/dl).

My Working Transplants: Pancreas and Kidney

by Susan J. Kucharzyk

Dear Fellow Diabetics—past and present:

I say that "past and present" in the most meaningful way! I was a juvenile diabetic for 22 years and for the past three years and seven months, I have not taken any insulin! I am on immunosuppressant drugs, also known as anti-rejection meds, since my transplant. Prior to my pancreas transplant on June 5, 1986, I received a cadaver kidney on July 1, 1985. When the pancreas was transplanted, I had to test my glucose level four times per day—now it is only twice a day. I take 580 milligrams of cyclosporine in the morning, 10 milligrams of prednisone and 100 milligrams of Imuran. I am very pleased with my progress and very lucky!

I cannot see out of my right eye at all, but I can make out small print with my left eye. The ophthalmologist told me in June of 1989 that I have a cataract growing in my good eye, but I'll have that removed after final exams in May of 1990. I am going into social work, as I love people, and I plan to go for my master's degree. I must finish my bachelor's degree first and then go from there.

My only regret is my Dad is not alive to see how well I have adjusted to my loss of sight and WORKING TRANSPLANTS! My father died in the hospital at the same time I was getting my pancreas transplant in June 1986. I know that Dad wanted this for me, and my Mom, too! My mom lives 55 miles away. I hope this letter is a spark of hope for all diabetics—it is a decision that YOU must make!

transplants been performed? The answer, in a word, is immunosuppression. The use of drugs such as prednisone, cyclosporine A and azathioprine is always necessary in order to keep the recipient's immune system from attacking the "foreign" pancreas and killing it. Unfortunately, these immunosuppressive drugs have serious side-effects. The risk benefit ratio to a patient is not always clear.

Why Transplant?

Despite the risks of immunosuppression, pancreas transplants in diabetics are done for one of two reasons; either the pancreas has failed and poses a danger to the health of other systems (kidney, eyes, nerves), or the failure of other organs, such as the kidney, makes a pancreas transplant a logical next step.

David Sutherland, M.D., professor of surgery at the University of Minnesota, explains; "If your kidneys have failed and you're on a dialysis machine, the side effect of the immunosuppressive drugs can be less harmful than the dialysis." And once a kidney transplant is done and the patient is put on regular doses of immunosuppressives, a pancreas transplant can be performed without having to weigh the pros and cons of administering the drugs.

"But even without a kidney transplant," he says, "individual pancreas transplantations have been performed when the complications of diabetes predict progression to end stage disease in one or more of the commonly affected systems—that is the eyes, nerves or kidneys."

In theory at least, he believes, "The ideal candidate for pancreas transplant is a Type I diabetic with early or moderately advanced complications. But, because transplant patients will have to undergo a lifetime of immunosuppression, we can perform the operations only in patients whose complications are or will become more serious than those caused by immunosuppression."

In the September 1988 issue of *Diabetes Care,* Dr. Sutherland wrote about the University of Minnesota team's further explorations. His conclusion was that given current immunosuppressive regimens, "transplant on these patients with early diabetic complications should definitely be carried out only in an investigative setting."

How Pancreas Transplants Are Performed

Obtaining a healthy pancreas for transplantation is the first challenge facing the surgical teams of miracle-workers.

Sometimes, the organ comes from a living donor. In such circumstances, the surgeon can transplant only a segment of the pancreas so that the donor can maintain normal insulin production. Most organs, however, come from cadaver donors. "We prefer whole organ transplants from cadaver donors," says Sutherland. "It is an easier operation than transplants from living related donors. However, some patients have antibodies to most of the population, and a suitable match cannot be found," he added. "For these individuals, a match may only be found with a close relative, such as a sibling or parent.

"Whether a whole pancreas or a segment of a pancreas is transplanted, the new organ can precisely regulate blood sugar levels," concluded Sutherland.

Preserving donated organs has been a challenge, but a new solution developed at the University of Wisconsin can keep them safely for up to 24 hours. According to Hans Sollinger, M.D., Ph.D., professor of surgery and pathology at the University of Wisconsin, "The pancreas is clearly one of the most fragile organs we transplant."

Once a donor is obtained, the patient is put on immunosuppressive drugs. This makes it possible for the body to accept the new organ.

The next step is to determine how the pancreas will be grafted into the body. This has been a very difficult area of research, but today there are some highly effective techniques that assure proper infusion of the insulin into the blood, provide proper drainage of the new organ secretions and allow doctors to monitor the ongoing health of the pancreas. If they can spot rejection early, before it does too much damage, it is often possible to keep the pancreas functioning.

The pancreas, once in place, needs to have a new drainage system created to replace the duct system that is lost in removal and transplant. The new technique for managing secretions, credited with the increased success rate of the operation, is the brainchild of Dr. Sollinger. As Dr. Sutherland explains, "The current popular method, introduced by Sollinger and his colleagues, is to make an opening joining the pancreatic duct of a segmental transplant or the duodenum of a whole pancreas graft directly to the bladder."

This drains the digestive enzyme containing secretions through the bladder, which is seemingly unaffected by the fluids. By monitoring the enzyme activity of these secretions, doctors now have the ability to detect early rejection. A decrease in

(Continued on page 12)

FOR THE NON-BRAILLE BLIND, USING THESE EVERYDAY ITEMS IS A FRUSTRATING CHALLENGE.

A can of ?

Doctor's number is ?

Microwave setting is ?

Using the Fishburne Code for identification, the frustration turns into a higher quality of independent living.

Thousands of the blind nationwide use the simple, easy-to-learn Fishburne Code to identify objects and make files.

If you know of a relative, friend or client that would benefit from this unique system contact us today for more information.

Fishburne Enterprises, Inc. • 221 N. Gordon Dr. • Winston-Salem, N.C. 27104 • 919/765-2928

ISOLATED ISLET OF LANGERHANS The purpose of pancreas transplantation is to reintroduce insulin-producing beta cells into the body. The beta cells are contained within the islets of Langerhans, comprising about 2 percent of the pancreas.

Pancreas Transplants Enter a New Decade

(Continued from page 11)

enzyme activity precedes a rise in blood glucose as a manifestation of rejection.

Other techniques drain the duct into the gastrointestinal tract, or use polymers to obstruct the duct. The former entails exposure to bacteria during the operation, increasing the risk of infection. The latter only allows blood sugar levels to be monitored to detect organ rejection. Most surgeons would rather have something better.

Do Transplants Really Help?

Pancreas transplants must do more than make a patient insulin-independent to be worth the risks and hardships. For both patients with advanced diabetic complications and those who are not yet incapacitated, it is necessary to prove that diabetic complications can be prevented, stalled or reversed. In 1987, a University of Minnesota team reported on this experience with diabetic recipients whose retinopathy, kidney disease or neuropathy were in the early stages. There was a marked decrease in the structural damage to the glomeruli (filtering units) of the kidney in patients whose pancreas grafts functioned for one year. Studies of nerve function showed that the progression of diabetic polyneuropathy may have been halted, if not reversed, by pancreas transplantation.

In the August 1988 issue of *Surgery,* Dr. Sutherland and colleagues from Minnesota reported on their overall findings: In 111 patients without end stage kidney disease who received a pancreas transplant, retinopathy remained stable in 59 percent of the patients and progressed in 41 percent; motor nerve conduction velocities were significantly increased and muscle action potentials remained stable in 24 patients. The effect on the kidney was mixed. Diabetic damage was halted. Unfortunately, one of the immunosuppressive drugs, cyclosporine, causes elevation of serum creatinine, one of the body waste products eliminated by the kidneys. After 6 months, however, kidney function remained stable. Overall, the team concluded, "A sustained normal glucose level can be established in diabetic patients who don't receive kidney transplants, with a beneficial effect on nerve disease, a lack of immediate benefit on advanced retinopathy and a positive effect on the kidney that is partially offset by the side-effects of immunosuppression."

Until there is solid evidence that the benefits of transplantation outweigh the risks of surgery and immunosuppression, the operation is not yet appropriate remedy for most patients who are not having a kidney transplant.

For patients who have end stage complications and are receiving a kidney, the benefits are easier to assess. The improvements they reap are a shot-free lifestyle and the prevention of diabetes-induced disease in their healthy new kidney. Since uremia, a side-effect of kidney disease, may worsen diabetic nerve and eye disease, the kidney transplant itself (not necessarily the pancreas) may help stabilize their other, more advanced complications.

Whatever progress has been made in the past ten years—and it is enormous—much more remains to be done. JDF and many fine researchers are pushing for the day when safe immunosuppressive drugs may make a pancreas transplant a relatively common alternative. The continual work by many centers to increase the availability of healthy pancreases helps bring us closer to the day. But one thing is certain—whether diabetes is prevented by transplantation, genetic manipulation, immunological magic or some yet unknown technique—JDF will continue to lead the search for a cure.

(*Note:* This article appeared Spring 1989 in *Countdown* Magazine, Juvenile Diabetes Foundation International. Reprinted with permission.)

National Senior Blind Committee Meeting Summary

by Catherine H. Randall

Catherine H. Randall is an active member of the National Federation of the Blind. She works diligently to improve the lives of senior blind citizens.

(**Editor's Note:** This article appeared in ***The Month's News***, the newsletter of the National Federation of the Blind of Illinois. We have much pertinent data for seniors, and welcome questions.)

The National Federation of the Blind committee dealing with concerns of the senior blind met Sunday evening, June 28, 1987, as part of the NFB National Convention in Phoenix, Arizona.

The meeting room was packed with the senior blind, other interested friends, and NFB members whose careers involve work with the senior blind. We spent two hours brainstorming and discussed a wide variety of ideas to help the senior blind improve the quality of their lives.

The ideas that follow are taken from my tape recording of the meeting. The group's enthusiasm was high because everyone had really come to learn and to share suggestions. It is a real privilege for me to serve as committee chairman.

1. *Social Security Supplemental Insurance.* Did you know that supplemental security insurance can help with expenses not covered by Medicare? You can apparently apply for this insurance only once a year. For more information, contact your local Social Security office, or, if you are still not given enough information, contact James Gashel, NFB Director of Governmental Affairs, 1800 Johnson Street, Baltimore, MD 21230. Phone: 301-659-9914.

2. *Non-Service-Related Disability Pensions.* If you know a World War II veteran or other veterans who are blind or who may be going blind, tell them that this apparently little-known pension exists. Contact your nearest Disabled American Veteran (DAV) Office or American Legion and/or VFW posts for more information.

3. *Talking Book Equipment in Nursing Homes.* Do not assume that nursing home residents or nursing home staff members know how to use Library of Congress cassette players and talking book machines. Showing staff and senior blind residents how to operate this equipment could be an on-going, continuous, local chapter project since employee turnover in nursing homes is high.

4. *Public Libraries Now Stock Low Vision Aids and Talking Books.* Some public libraries in South Dakota, for example, are now lending low vision reading aids to people who are interested in trying such aids at home before purchasing them. These libraries also keep aids on hand for people to use at the library. South Dakota libraries that choose to, also have talking book equipment and books available to be used at the library or to be checked out.

5. *Survey of Blind Nursing Home Residents.* The Dayton, Ohio, chapter of the NFB, in cooperation with the Montgomery County Nursing Home

Association, has surveyed nursing homes county-wide to learn how many blind people are residents of each home and who they are. The Association provided the Dayton chapter with a list of homes in the county. Chapter members plan to work with any senior blind friends found through this survey on a one-to-one basis. The survey also found a 21-year-old man who had been "dumped" in a nursing home by his family who could not or who did not choose to deal with his blindness. When chapter members first met this young man he knew no skills of blindness. Chapter members will help this man receive proper rehabilitation and eventually help him to move into an independent living situation if possible.

The chapter also plans to see that a radio-reading service sub-carrier receiver is available to residents in each area nursing home.

6. *Federal Grant Money to Aid Senior Blind On A State-By-State Basis.* The vocational rehabilitation agencies serving the senior blind in each state can apply for federal funds to be used exclusively for services to the senior blind. In 1987, grant proposals had to be submitted by July 20. The NFB in South Dakota was asked to help provide input by writing a letter of support for the grant proposal. NFB state president, Karen Mayry, agreed to write a letter of support if she could read the proposal before it was submitted. Karen read and approved the proposal and wrote the letter. Such federal funds have provided cane travel instructions for seniors and labeling of appliances in their homes. Rehabilitation teacher assistance has been hired to help teachers with follow-up tasks such as delivering talking book equipment, helping seniors write out lists of telephone numbers, etc. According to NFB members, Judy Rasmussen and Cathy Sullivan, this funding has proved successful and a great help to the senior blind, in their areas. These funds are provided under Section VII of the Rehabilitation Act, but you must push Vocational Rehab for information.

7. *Peer Counseling by NFB members* was stressed as the most effective support system for the senior blind. Peer counseling must involve the right kind of positive blind people sharing experiences with newly blind or not-so-newly blind seniors. People who project good role models for others can put their experiences coping with blindness on tape to be shared with seniors who are just learning about the Federation. We must take our peer counseling into people's homes, but if transportation is a problem, tapes can be a bridge to help build solid friendships with new blind friends.

8. *The Senior Blind As Fund Raisers.* In South Dakota, the senior blind from around the state work on crafts fund-raising projects throughout the year. They meet on a weekly basis and create and sell their crafts to benefit the NFB. A Federation fellowship is shared, people compare the use of skills of blindness to best advantage, and have a good time in the process.

9. *Transportation.* One participant in the meeting had very little opportunity to visit her husband in a nursing home fifty miles away. We suggested she send him tapes on a regular basis and that she contact local civic clubs to see if members might be willing to drive her there for visits. Ask service clubs for transportation assistance to help you improve the quality of life for other blind people.

10. *Diabetes And The Senior Blind.* Diabetes and its complications including blindness, strikes many senior citizens. The diabetics division of the NFB produces the magazine ***Voice of the Diabetic*** on tape and in print. For more information, contact Ed Bryant, Editor, the Diabetics Division of the National Federation of the Blind, 811 Cherry Street, Suite 306, Columbia, Missouri 65201. Office Phone: 314-875-8911.

I hope you have found the information presented here to be relevant. Please send any suggestions to Catherine H. Randall, Chairman, Senior Blind Committee, 1260 West College, Jacksonville, Illinois 62650. Phone: 217-243-3529.

Americans

At this time of the year, people tend to think of their relations with their fellow man, particularly their relations with minority groups. But most Americans do not think of the blind as a minority with all the problems, hopes and dreams which that implies.

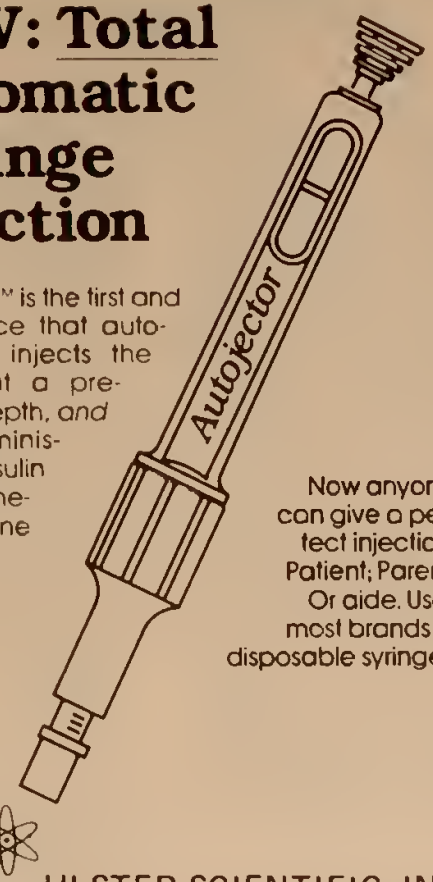
However, the blind are a minority, not only in numbers, but in social acceptance. This is why we have formed the National Federation of the Blind, to increase public understanding and to bring opportunity and first-class citizenship to the blind. One out of every 500 of the total population is blind, and there is probably a chapter of The National Federation of the Blind in your locality.

For further information about our aims and programs or about blindness, write Mr. Marc Maurer, President, National Federation of the Blind, 1800 Johnson St., Baltimore, MD 21230; phone: (301) 659-9314, or contact your local federation chapter.

If you see our literature in the mail or meet one of us, remember that the National Federation of the Blind is a nationwide organization of blind people and that all our officers and members work on a volunteer basis to better the lives of the blind.

NOW: Total Automatic Syringe Injection

Autojector™ is the first and only device that automatically injects the needle at a prescribed depth, and also administers the insulin . . . all at the touch of one button.



Now anyone can give a perfect injection: Patient; Parent; Or aide. Uses most brands of disposable syringes.

USI ULSTER SCIENTIFIC, INC.
P.O. BOX 902 HIGHLAND NEW YORK 12528
New York State - (800) 522 2257
Outside New York (800) 431 8233

Good News About Medicare Fairness

by Bruce Fried

Big news from the American Medical Association (bear with me, this is not an advertisement for doctors): the number of doctors accepting the Medicare payment rate for all of their patients just increased dramatically.

Until recently, only three doctors in ten would guarantee that they wouldn't charge Medicare patients any more than the official Medicare fee schedule. This summer, things started changing. Suddenly, the number guaranteeing that they won't charge you more than the Medicare rate went up to nearly four in ten.

As you'd probably guess, the story isn't the same everywhere. If you live in Alabama, chances are three to one that your doctor always accepts assignment (that's Medicare jargon for "don't worry, they won't charge you more than what Medicare says is reasonable"). In Kansas, Rhode Island, Tennessee, Hawaii, West Virginia, Arkansas and Utah more than half of the doctors guarantee that they'll accept assignment for every Medicare patient and never charge more.

But watch your wallet if you get sick in Idaho! The state is beautiful and the potatoes are delicious, but the doctors have hard hearts. Fewer than one out of six Idaho docs will guarantee the Medicare rate! (To be fair to Idaho, doctors in several other states are almost as bad: South Dakota, Montana, Wyoming, Connecticut and Colorado.)

HUGE OVERCHARGES

Of course, almost all doctors in Idaho and every other state are ready to take Medicare money. Last year they took $19 billion dollars from Medicare: that's an average of about $40,000 per doctor. But they still refuse to hold to the Medicare fee schedule. And that costs you a lot of money! When your doctor agrees to take assignment, you never have to pay more than 20%. Medicare pays the rest (after your deductible). But doctors who don't take assignment can make you pay 30%, 40%, 50% or more.

When the National Health Care Campaign surveyed the problem, we found that doctors you know personally are the ones who usually accept assignment: internists, and family doctors. It's the doctors you don't know so well, the ones you see briefly when you're in the hospital, or never see at all, who really stick it to you. Surgeons, anaesthesiologists, pathologists and radiologists—doctors you're in no position to shop around for—have the lowest rates of accepting assignment.

And, guess what? These are the doctors who send you the highest bills. So the difference between 20% and 40% could be hundreds—or thousands—of dollars.

The real question is: if some doctors can guarantee fair rates, why

(Continued on page 14)

Fast Food Facts

Nutritive and Exchange Values for Fast-Food Restaurants

by Marion J. Franz, R.D., M.S.

From The Editor: Following is a condensed version of a book written for the general public and not specifically for diabetics, but it can be valuable as it extensively charts the nutritive food values for over 25 fast food restaurants. As diabetics, we should minimize our visits to these establishments, but an occasional visit will probably not affect overall diabetes management. Fast food meals are high in calories, fat, and sodium. About 685 calories are contained in the average meal, however the average snack is 427 calories. As diabetics, we should be extra cautious about partaking in snacks at fast food restaurants. This book may help conscientious diabetics be judicious in their food choices. The book, **Fast Food Facts,** by Marion J. Franz, R.D., M.S., © 1987 Diabetes Center Inc., Wayzata, MN is reprinted with permission. For ordering information please refer to our resource column.

Individuals with diabetes will no doubt at times find it convenient or necessary to eat fast foods. When you do, the following guidelines can help you make wise decisions. Know your meal plan. You will need to choose foods that fit into your available exchanges for meals or snacks. Avoid high sugar and high fat foods. If weight is a concern, pay special attention to caloric values and avoid high-sugar, high-fat and high-calorie foods. You may need to supplement a fast-food meal with some fruit and/or skim milk. Fast-food restaurants that provide salad bars are good choices. Nutritional adequacy can be assured by eating a variety of vegetables, fruits, low-fat milk and whole grain foods in the rest of your meals and snacks during the day.

Know the nutritional value of fast food items. The nutritional values of foods at fast-food chains may be easier to predict than at some expensive gourmet restaurants. Studies of the leading chains show remarkable uniformity in portion size and nutritional value of their foods. This book has been designed to alert you to the nutritive value of food items and their exchange values, thus helping you to make wise food choices.

Avoid the high-fat, high-saturated fat items. Saturated fats and cholesterol are commonly found in meats, dairy products and eggs. Avoid large orders of high-fat foods, such as a double cheeseburger. Instead, settle for a more moderately sized burger, such as a plain quarter pounder. Beware of the high-fat, mayonnaise-based sauces added to hamburgers, as well as items such as french fries cooked in saturated fat. Sources of hidden fats and sugars are shakes, fries, pies and soft drinks. Set your goal for 4 teaspoons of fat per meal (1/3 of the day's total of 13 teaspoons).

Go easy on salt. Many fast foods are extremely high in salt. Additional items that are high in salt are ketchup, pickles, mustard, tartar sauce, salad dressing, and other condiments. Salt is 40 percent sodium, and too much sodium is related to high blood pressure. The average American easily eats 10 to 60 times the 0.2 grams of sodium needed per day. The recommendation of many health and nutrition organizations is to limit daily sodium intake to 2,300 milligrams—the amount found in 1 teaspoon (5 grams) of salt. Sodium values in milligrams per serving are included in this book to help you regulate your sodium consumption. Aim for not more than a total of 1/2 teaspoon of salt per meal (700 milligrams).

Make wise choices. If you have fast foods for one meal, try to balance the rest of your day's food choices.

It is important to know facts about fast food when considering diabetes. Today in the United States, 200 customers order one or more hamburgers every second! From 1970 to 1980, the number of fast-food restaurants increased from 30,000 to 140,000. Sales in 1970 were $6.5 billion, in 1980, $23 billion, and in 1986, $34 billion. This is approximately 40 percent of total annual sales for all U.S. restaurants, or $2 of every $5 spent in restaurants. U.S. consumers spend an average of $200 a year on fast food.

But trends suggest that consumers have become increasingly concerned about the nutritional quality of food, resulting in the introduction of salad bars, less salty foods, "lite" (low calorie) items and smaller portions.

A 1983 Gallup survey showed that six out of ten consumers have changed their eating habits at home and are eating more fruits, vegetables and whole grains while decreasing their intake of refined sugars, animal fats and salts. Four out of ten adults said they sustained these dietary changes when eating out. More than one-half of those interviewed considered nutrition an important aspect of fast food.

A 1986 Gallup survey on consumer trends found that one-fourth of all meals are eaten away from home, and 50 percent of those are lunches. Furthermore, 59 percent of the people surveyed reported they were increasingly concerned with nutrition, and more than 50 percent of those eating out were eating smaller portions.

As a result of this consumer concern, salads, fresh vegetables, fresh fish, decaffeinated coffee and fresh fruit are becoming increasingly popular as restaurant menu items. However, even among the nutrition-conscious, the hamburger is still the most commonly ordered food in American restaurants. This helps account for the continued popularity of fast-food restaurants. When Americans eat out, they want familiar foods that taste good.

The goal Americans should have in mind is to eat a variety of foods in moderate portions chosen within a prudent nutritional framework—no more than 25 to 30 percent of calories from fat, no more than 1,100 to 3,300 milligrams of sodium daily, plenty of foods high in fiber, and a few high in sugar. Thirty percent of calories from fat in a 2,000 calorie diet translates into roughly 13 teaspoons of fat per day, and the amount of salt equal to 3,300 milligrams of sodium is 1 1/2 teaspoons. Furthermore, a prudent eating pattern should contain only enough calories to maintain weight no higher than 10 percent above the ideal weight for any one person's height and body frame. These are not always easy guidelines to follow, and eating fast foods can make eating right even more difficult. Let's see why.

Calories. For most people, the greatest nutritional problem with typical fast foods is the number of calories. A quarter-pound burger with cheese, fries, and a shake contains about 1,130 calories, which is considerably more than most dinners prepared at home. This meal contains 53 grams of fat, making up 43 percent of the total calories. The whole meal contains about 40 percent of the daily calories needed to maintain the weight of a 165-pound man, and 60 percent of the calories needed by a 128-pound woman. For someone on a diet, 1,130 calories is a substantial portion of the entire day's allowance of calories. Teenage boys can consume high-calorie meals without much of a problem, but the rest of us cannot afford to eat so much of one day's calorie allotment in one meal.

Fat. Where do all of the calories in fast foods come from? Fat. Fat (specifically saturated fat and cholesterol, both of which can contribute to heart disease) and sugar provide most of the calories in fast foods without providing any of the other important nutrients, such as vitamins and minerals.

On the average, 40 to 60 percent of the calories in fast foods come from fat. Many fast food entrees are high in fat and calories because they are fried. To top it off, many restaurants fry foods in highly-saturated beef fat that contains high levels of cholesterol.

Many people think that chicken and fish items are the best choices at fast-food restaurants because chicken and fish are traditionally lower in calories and fat than beef or other red meats. However, these choices may be worse than the beef in fast-food restaurants because they

Good News About Medicare Fairness

(Continued from page 13)

can't they all? After all, doctors who accept Blue Cross payments agree to Blue Cross fee schedules. Why shouldn't doctors who are making tens of thousands of dollars from Medicare agree to Medicare fee schedules?

Last year, doctors who refused assignment charged their patients $2.5 billion more than the reasonable Medicare fees!

It isn't as if doctors were starving. The average doctor makes more than $120,000 a year after expenses, including malpractice insurance! The average senior citizen is scraping by on less than $15,000 a year. It's really a matter of common decency. Doctors shouldn't take advantage of old people by charging fees above the fair Medicare rates.

WHAT SHOULD BE DONE?

How to achieve fairness? One way would be for the American Medical Association to provide leadership and urge doctors to "accept assignment." Unfortunately, the leaders of the AMA and the state medical societies have been the worst offenders. Hardly any of them take assignment for 100% of their own Medicare patients.

A second way is the Massachusetts example. Doctors there are required by law to take assignment, guaranteeing that nobody will be charged even a penny over fair Medicare rates.

A third way is for older Americans to get together and start speaking up as consumers. In communities all across the country, organized seniors have successfully convinced hospitals to require their doctors to take assignment.

If you want information on where there is a seniors' group near you, write to me at the National Health Care Campaign, P.O. Box 27434, Washington, DC 20038.

(*Note:* This article appeared Oct., 1988, *Senior Citizens News*, Rapid City, SD; reprinted from the *Senior Watch* newsletter of the Villers Foundation. The author, Bruce Fried, says we might direct readers who are interested in the issue, or in the effort to win a national health care system which provides affordable, quality health care for all Americans to: National Health Care Campaign, P.O. Box 27434, Washington, D.C. 20038, (202) 539-8833.)

are usually coated with batter and deep fried. The batter acts as a sponge, absorbing large amounts of fat during the frying process, so chicken and fish products may, in the end, contain more fat (9 teaspoons) and calories than a hamburger or roast beef sandwich. You can usually order a roast beef sandwich AND fries for less fat than you get in a fried chicken breast sandwich alone!

Sugar. Sugar is added to food to improve taste as well as appearance. The greatest source of sugar is soft drinks and shakes. In 1985, the average American drank 484 12-ounce cans of soda pop, each can containing 8 to 11 teaspoons of sugar. Shakes also get most of their 350 calories from sugar. A typical shake contains about as much sugar as a 12-ounce can of regular soda pop (9 to 11 teaspoons), with 2 to 4 teaspoons of fat. A 14-ounce shake has 760 calories, and a 20-ounce shake has 990 calories.

Sodium. Some menu items also contain large amounts of sodium (salt) which can contribute to high blood pressure. Several fast food sandwiches contain 1,500 to 1,750 milligrams of sodium (2/3 to 3/4 teaspoon of salt), more than one-half of the daily recommended sodium intake of not more than 3,300 milligrams. The sodium level of a fast-food meal rises quickly if the consumer selects salted French fries, onion rings, or a milk shake.

A single cheeseburger can contain 1,400 mg. of sodium—half the maximum recommended daily level. A fish dinner contains more than 2,000 mg.—1 teaspoon of salt.

It is difficult to know by taste how much sodium is in food. Surprisingly, French fries can be the lowest in sodium. Salt is sprinkled on before and after frying, which makes the fries taste salty, but the sodium level is lower than that of many other menu items.

To their credit, McDonalds reduced the amount of sodium in their food items by an average of 15 percent between 1984 and 1985. However, an Egg McMuffin still contains 885 milligrams of sodium, and the new McD.L.T. has 1,030 milligrams of sodium, so there is still plenty of room for improvement.

Fiber. Sources of fiber, such as fruits, vegetables, and whole grains, have not been traditional fast-food offerings. The average American consumes 10 to 20 grams of dietary fiber per day, but the recommended intake is twice that level.

For most people, an occasional meal at a fast-food restaurant will not upset an otherwise well-balanced diet. People who eat fast foods regularly, however, need to choose menu selections with more care:

Calories. Today many fast-food restaurants offer salad bars, low-calorie salad dressings, soups, baked potatoes, baked fish, sugar-free soft drinks, low-calorie beverages, and low-fat milk that can help the calorie-conscious consumer limit calories, fat and sodium in a meal. A salad or baked potato will add complex carbohydrates and fiber, which are missing from traditional fast foods. If you go easy on dressing, butter or margarine, and toppings, your meal will contain very little fat and sugar as well. A meal consisting of a plain hamburger (without cheese or mayonnaise-based sauces), salad, and a diet soda is relatively low in calories (450 calories).

The key to reducing calories is to buy small and eat only at meal times. The average calorie count of a fast-food meal is 685, which is not outrageously high. However, many people buy fast-food items as snacks rather than meals; the average calorie count for a so-called snack is 427. Added to regular meals, that many calories can put individuals well over their caloric requirements.

Fat. To avoid fat, "hold the sauces" such as mayonnaise, and tartar sauce. One serving of a mayonnaise-based topping can add more than 100 calories. A hamburger without mayonnaise saves approximately 150 calories, and ordering it without cheese saves another 100 calories. Skip the "special sauces;" instead, add lettuce and tomato for a California burger. Rather than a double cheeseburger (high in fat), settle for a more moderately-sized burger, such as a plain quarter pounder.

Deep-fried foods contain more fat than grilled or broiled foods. If you do order fried foods, discard the breading and avoid the "extra crispy" version. Fried foods, such as chicken, fish, pie, and French fries contain as much as 40 to 60 percent fat. Look for broiled or baked fish and season with lemon juice instead of butter and tartar sauce. Look for baked or broiled chicken as well, hold the sauces, and discard the breading.

Processed meats are high in fat, so avoid bacon on your burger, pepperoni on pizza, and sausage on a biscuit. A plain pizza topped with vegetables instead of meat is much lower in fat. Two slices of a 16-inch cheese pizza contain 400 calories, only 18 percent of which are from fat. Order pizza with mushrooms, green pepper and onions. When you add pepperoni, sausage, anchovies or extra cheese, you add unnecessary fat, sodium, and calories.

A plain baked potato is nourishing, filling, and virtually fat and sodium free. If you add toppings, use a minimum of sour cream, margarine, or butter. A plain, large potato weighing 10 1/2 ounces provides 250 calories and 2 grams of fat. Toppings increase the fat level from 2 grams to 30 or 40 grams, and the calories soar from 250 to 590. A deluxe super-stuffed baked potato with sour cream, butter, bacon, and cheese has 640 calories and 6 teaspoons of fat.

Salad bars provide low-fat alternatives, but be careful of high-fat toppings such as regular dressings, bacon, cheeses, seeds, and eggs. A salad from a salad bar (as opposed to a prepared salad) averages 80 to 100 calories. Three tablespoons of regular dressing will add 134 calories, but a reduced calorie Italian adds only 75 calories. Avoid items that are mixed with dressings, such as potato, carrot, or macaroni salads, which contain mayonnaise or oil. Choose fresh fruits instead of canned fruits in heavy syrup to cut back on sugar.

If you can find a roasted chicken breast sandwich on a menu (one that is not deep fried) you are in luck. It will be both lower in fat and lower in calories (254) than other menu items. Roast beef (345 calories) or French dip sandwiches are also relatively low in fat; however, they both have high levels of sodium, (1,111 mg.). A plain roast beef sandwich is lower in fat than a hamburger, but the fat and calories add up when topped with bacon, cheese, and sauces.

Croissant sandwiches are high in calories, fat, and cholesterol; one croissant averages 200 to 500 calories. Compare this with a whole grain bun which has just 135 calories. Croissant sandwiches average 400 to 600 calories, which is high compared with 350 calories for a plain roast beef sandwich, or 285 calories for a pita sandwich.

Super hot dogs with cheese have 8 teaspoons of fat along with 1,605 milligrams of sodium. Add a large malt with 1,060 calories—estimated to contain 25 teaspoons of sugar—and you are in trouble. Stick to the single hamburger with lettuce and tomato, small ice cream cone, and diet soda pop.

An order of French fries can range

(Continued on page 16)

JOCELYN BISCHOFF'S DIABETIC
THREE GENERATIONS OF MEDICAL SALES

Dia-Pak Carrying Case $17.50

- Simple One Touch procedure
- Reduces potential for error
- Proven most accurate among leading meters

LIFESCAN

One Touch System

Complete Kit
$129.95
Less Mfg's. Rebate $50.00
Less Mfg's. Trade-In $50.00
$29.95

One Touch Strips
1–3 pkgs of 50 ..... $26.50
3–5 pkgs of 50 ..... $26.20
6–9 pkgs of 50 ..... $25.95
9 or more $25.85

Meter Only
$109.95
Less Mfg's. Rebate $50.00
Less Mfg's. Trade-In $25.00
$34.95

Glucoscan 3000 $109.00
$65.00 Mfg's. Rebate
$25.00 Trade-In
$19.00

408-438-2454 1-800-537-0404
219B Mt. Herman Road Scotts Valley, CA 95066

Eat Your Milk

by Claire C. Hammer, R.D.

Most likely milk is figured into your meal plan. Milk products are the best foods for calcium, which your body needs no matter how old you are. There are other foods that you may find on other food lists that are also high in calcium, such as cheese and cottage cheese. But because many cheese items are high in fat and cholesterol, eating too much of these is not recommended. Low-fat milk choices from the MILK EXCHANGE are your best choices for calcium-rich foods without all the fat and cholesterol.

If you do not like drinking milk, 1 cup of non-fat yogurt is equal to 1 cup of low-fat milk. Read yogurt labels carefully. Many yogurts will say "low-fat" and indeed they are. But "non-fat" will be much lower in fat than "low-fat." Make sure you buy a "non-fat" yogurt that is not flavored. Many people find the yogurt tastier if they use one of their fruit choices to mix into the yogurt along with some artificial sweetener.

You can also cook with milk and disguise it that way. Use your milk allowance in soup, puddings and custards. Many cookbooks written for people who have diabetes include milk in the recipes, and a serving may count from ½ cup to 1 cup of milk.

Some people are sensitive to the sugar that is found naturally in milk. This sugar is called lactose. People who are "lactose intolerant" can usually tolerate yogurt and some aged cheeses. Also, some individuals find that they can even tolerate milk if they drink smaller amounts more frequently throughout the day.

Be sure to tell your dietitian if you do not care for milk or if you have problems tolerating it. Meal plans can be figured out so that not too much milk is included for you. But remember that milk is one of the best sources of calcium and every effort should be made to include about 2 cups a day if possible.

CHOCOLATE MOUSSE
(8 servings)

1 envelope unflavored gelatin
2 T. unsweetened cocoa
2 eggs, separated
2 cups low-fat milk
5 packets Equal
1½ tsp. vanilla extract

In a medium-size saucepan, mix gelatin and cocoa. In separate bowl, beat egg yolks with 1 cup milk. Blend into gelatin mixture. Let stand a minute to soften gelatin. Stir over low heat until gelatin is completely dissolved, about 5 minutes.

Add remaining milk, Equal and vanilla. Pour into large bowl and chill, stirring occasionally, until mixture mounds slightly when dropped from spoon.

In separate bowl, beat egg whites until soft peaks form; gradually add gelatin mixture and beat until doubled in volume, about 5 minutes.

Chill until mixture is slightly thickened. Gently pour into dessert dishes or 1-quart bowl and chill until set.

½ CUP = ½ CUP LOW-FAT MILK EXCHANGE

Reprinted with permission from *Diabetes Forecast.* Copyright American Diabetes Association, Inc.

TOMATO BUTTERMILK COOLER
(3 cups)

1 cup spicy tomato vegetable juice
1 tsp. lemon juice
2 cups cold buttermilk
3 ice cubes

Place all ingredients in blender container; cover. Blend until well combined. Serve immediately in tall, chilled glasses.

1 CUP = 1 LOW-FAT MILK EXCHANGE

Reprinted with permission from the American Dairy Assoc. of Michigan

PUMPKIN CUSTARD
(6 servings)

1 envelope unflavored gelatin
¼ cup cold water
3 eggs, separated
1¼ cups pumpkin
½ cup skim milk
½ tsp. ginger
½ tsp. cinnamon
½ tsp. nutmeg
½ tsp. salt
1 T. liquid sweetener

Sprinkle gelatin on cold water and let stand 5 minutes. Put egg yolks into the top of a double boiler and beat slightly. Add pumpkin, milk, spices, salt and sweetener and cook until thick. Add soaked gelatin and cool thoroughly. Fold in egg whites which have been beaten stiff. Pour into 6 molds and cool in refrigerator.

1 SERVING = ½ LOW-FAT MILK EXCHANGE

Fast Food Facts

(Continued from page 15)

from 210 calories with 2 teaspoons of fat up to 400 calories with 4 to 5 teaspoons of fat. Limit French fries to small servings, and ask the clerk to hold the salt.

Breakfast biscuits start your day with 500 to 700 calories, 30 to 35 grams of fat, and more than 1,000 milligrams of sodium. A sausage and egg croissant contains 645 milligrams of cholesterol—more than double the recommended amount of 300 milligrams a day.

Sodium. To lower sodium consumption, order foods without condiments. One tablespoon of ketchup contains 150 mg. of sodium, and 1 tablespoon of mustard contains about 180 mg. Together, they make up nearly 1/5 of your total daily salt allotment. To cut down on salt, hold pickles, ketchup, and special sauces.

A plain baked potato has 60 mg. of sodium. When bacon and cheese are added, the sodium level skyrockets to 1,180 mg (1 1/2 teaspoons of salt).

Fiber. Beans are one of the best sources of fiber; baked beans, chili with beans, and refried beans all add fiber to your meal. At the salad bar, kidney beans, garbanzo beans, and fruit add fiber. Baked potatoes with skin are another good choice for fiber; however, ordering only the skins usually means deep-fat fried skins with salty, fatty toppings.

Whenever possible, order whole grain buns, but be wary of "wheat" bread products containing caramel coloring to make them look dark. They are not rich in whole grains. You should see flecks of fiber in your whole wheat bread products.

Let's look at some good choices you can make at fast food restaurants.

For a fast but healthy breakfast, try a toasted whole grain English muffin with a small amount of butter, low-fat milk, and fruit or fruit juice. A scrambled egg with an English muffin, totals only 366 calories, with 17 grams of fat and 575 grams of sodium. This is still a substantial breakfast, but it has less fat, sodium, and calories than many other fast food breakfasts. A surprisingly good option is pancakes with butter. They have less fat than croissants and are relatively cholesterol free. If you have diabetes, use diet jam, jelly, or syrup.

For lunch, a sandwich with lean meats—roast beef, turkey or ham—and whole grain bread can be a good choice. Ask them to hold the butter, margarine, or mayo. Roast beef sandwiches can be better than hamburgers—even the fattest roast beef sandwich is leaner than the leanest hamburger. Avoid anything labeled "big", "deluxe", or "whopper". The smallest hamburger and sandwich will be the lowest in calories and fat. Buy small—avoid double and triple sandwiches. Hold condiments such as tarter sauce, mayonnaise, bacon, and cheese to further reduce the fat and calories. A roasted chicken breast sandwich is a wonderful choice.

A salad bar is a healthy alternative to high-fat sandwiches. A large salad containing a variety of vegetables, 1/2 cup of cottage cheese, and reduced-calorie salad dressing has less than 250 calories. However, by adding just 1 tablespoon of regular dressing, some bacon bits, and 1/4 cup of macaroni or potato salad, you increase the calorie level to 500. A salad from the salad bar averages 100 calories. Two tablespoons of reduced-calorie dressing has 50 calories. If you add cole slaw (1/2 cup, 90 calories), sunflower seeds, and raisins (1/4 cup, 180 calories), you quickly add extra calories.

Wendy's has joined the nutrition bandwagon by combining standard menu items with a "light menu," which includes a baked potato, the salad bar, a side salad, diet soft drinks, and a multi-grain bun. The salad bar has 20 items, including fresh fruits and vegetables that are rotated according to season, and four reduced-calorie dressings.

As for accompaniments, save calories and sugar by drinking non-caloric beverages. Skip fast-food dessert; instead satisfy yourself by bringing fresh fruit from home. Try eating your "dessert" fruit first; it is a creative way to curb your appetite and avoid overeating.

Finally, do not snack at fast-food restaurants; fast foods are more likely to fit into your allowances for full meals. And when you eat a fast-food meal, try to be especially conscious about your food choices for the rest of the day, avoiding high-fat, high-salt items. The key to nutritious fast food eating lies in rounding out your diet the rest of the day.

Achievement

Achievement is made of high hopes, of hard work, of dreams and drudgery. The blind of America are willing to work and work hard, but we also dare to dream. This is the story of the National Federation of the Blind. This is why we, as blind people, have organized and why we seek your help and understanding. When you see our literature in the mail or meet us on the streets, think of us as people, as fellow citizens just like you, with all the range of talents and weaknesses, wants and wits that you possess. The

National Federation of the Blind is the blind speaking for themselves with a positive voice.

Ann Terry is a registered dietitian. She works at the State Hospital in Fulton, Missouri and at the Veteran's Administration Hospital of Columbia, Missouri. She graciously calculates the diabetic exchanges and food values for our recipes.

Send your great ideas to the editor. He is the official taste tester and needs recipes to test his taster.

No-Salt Recipe

(NOTE: This recipe appeared in the *Kidney Kazette,* Summer 1989, published by: Dialysis Clinic, Inc., Columbia, MO)

½ tsp. garlic powder
¼ tsp. powdered thyme
½ tsp. onion powder
½ tsp. paprika
¼ tsp. ground celery seed
½ tsp. white pepper
½ tsp. dry mustard

Egg Substitute

Submitted by Anonymous

3 egg whites
2 tbsp. skim milk
1 tbsp. nonfat dry milk
1 tsp. vegetable oil
Yellow food coloring (optional)

Beat egg whites lightly with a fork. Dissolve nonfat dry milk powder in the fluid skim milk. Add the milk mixture and oil to egg whites and beat until thoroughly blended. A few drops of yellow food coloring can be added to achieve the color of whole eggs.

This amount of egg substitute is equivalent to 2 whole eggs.

Egg substitute can be scrambled, made into omelets, used for French toast, or used in many recipes calling for whole eggs.

Yield: 1 serving; Calories: approx. 120; Diabetic Exchanges: 1 ½ meat.

Jelly Recipe

(NOTE: This recipe appeared April 19, 1988, in the *Rapid City Journal,* Rapid City, SD)

One quart apple juice
4 tbsp. artificial sweetener
2 tbsp. lemon juice
2 pckgs. unflavored gelatin

All of the ingredients should be mixed well.

Boil the mixture gently for five minutes. Let cool and then pour into containers and store in the refrigerator.

This recipe does contain natural sugar, so you will need to figure the calorie and sugar count for it. I just love it! — Heloise.

Yield: 70 servings; Calories: 7; Diabetic Exchanges: Free exchange 4 Tbsp = ½ fruit.

(NOTE: The following recipes appeared in the column, "Health-o-Rama," in the July, 1988 edition of the ***Senior Citizens News,*** *Rapid City, SD)*

Fruit Dip

Submitted by Sandy Morrison

2 8-oz. yogurts, nonfat or lowfat (plain)
1 8-oz. cool whip
1 cup pureed fruit (fresh or unsweetened)

Since I used plain yogurt, I purreed some strawberries and added them for flavor.

Mix with hand mixer on low.

Yield: 10, ½-cup servings; Calories: 100; Diabetic Exchanges: ½-cup skim milk = 1 fat.

Herbed Baked Fish Fillets

(From *No Salt-No sugar-No fat* cookbook — Made by Agnes Schamber)

1 lb. fish fillets
½ c. whole wheat flour
½ tsp. garlic powder
½ tsp. oregano
1 tsp. freshly grated ginger
1 egg white
½ c. plain low-fat or nonfat yogurt (This keeps the fish from becoming dry.)

Combine flour and herbs. Dip fish in egg white then in flour mixture. Place fish in single layer in baking pan. Spoon yogurt over fish. Bake in preheated 400 degree oven about 15 minutes.

Yield: 4 servings; Calories: 200; Diabetic Exchanges: 2 lean meat, 1 bread

Oat Bran Muffins

Submitted by Peggy Van

(NOTE: This recipe does contain a moderate amount of simple sugar. These muffins are in the same category as angel food cake and ice cream. One muffin may be consumed occasionally.)

1¼ c. oat bran cereal
1 c. flour or whole wheat flour (half and half is good)
⅓ c. snipped dried apricots (about 6 or 7)
1 tbsp. baking powder
½ c. skim milk
½ c. orange juice
¼ c. honey
2 tbsp. oil
3 egg whites (or 2 eggs)

Preheat oven to 425 degrees. Mix all dry ingredients in food processor (Peggy's little Oscar worked fine). Add wet ingredients and egg whites (with a pinch of salt, if desired). Blend briefly. Do not over-mix.

Divide into a nonstick muffin pan sprayed with Pam or fill paper-lined muffin cups. Bake for 15 to 20 minutes. Serve warm with low sugar spread. This is cooking the low-cholesterol way.

Yield: 12 muffins; Calories: 130; Diabetic Exchanges: 1 bread, ½ fruit, ½ fat.

Fruit Spritzer

(From American Heart Association)

1 can unsweetened frozen juice concentrate
Club soda

Mix frozen juice concentrate according to directions on the can, substituting club soda for water.

Yield: 3 cups; serving size: ½ cup; Calories: 60; Diabetic Exchanges: 1 fruit.

What You Always Wanted to Know But Didn't Know Where To Ask

(Resource List)

(Inclusion of materials in this publication is for information only and does not imply endorsement by the Diabetics Division of the NFB.)

Equipment

One Touch Blood Glucose Meter: Complete kit is $129.95, or meter only for $109.95. Manufacturer's rebate and/or trade-in drop price to $29.95 for the kit, $34.95 for the meter only. Carrying case and other meters and supplies available. Contact: Jocelyn Bischoff's Diabetic Supply, 219B Mt. Herman Road, Scotts Valley, CA 95066; telephone toll-free: 1-800-537-0404.

Alcom Accent Text-To-Speech Synthesizer: Converts text on your computer screen to speech, with vocabulary of over 20,000 words. Five models: full-length ($745) or half-length ($395) plug-in cards for IBM-PC compatibles; cards for Toshiba laptop models T1200 or T1600 ($625); stand alone unit with RS-232C link to any computer ($940). Supported by all major screen reader programs. Contact: Alcom Corporation, 2375 Zanker Road, Suite 205, San Jose, CA 95131; telephone: (408) 922-0855.

Sleep Sentry: Worn like a watch to warn diabetics of nighttime insulin reactions. Perspiration triggers alarm. Cost: $240 plus $2 handling. Contact: Diabetes Supplies, Inc., 8181 North Stadium Dr., Houston, TX 77054; telephone toll-free: 1-800-622-5587 or in Houston, (713) 662-5587.

Fishburne Code: A tactile identification system for those unable to use Braille. It doesn't replace Braille, but it is a good alternative. Training materials cost about $25.00 and equipment about $40.00. The approximate total cost, which includes cassette instructions, is about $65.00. The cost is less for persons not requiring entire unit. Contact: Fishburne Enterprises, Inc., 221 N. Gordon Dr., Winston-Salem, NC 27104; telephone: (919) 765-2928.

Autojector: Automatic insulin injection system that "automatically injects the needle at a prescribed depth." Suggested retail price: $39.95; contact: Ulster Scientific, Inc., P.O. Box 902, Highland, NY 12528; telephone toll-free: 1-800-431-8233; in NY call: 1-800-522-2257.

Diascan-SVM Blood Glucose Meter with Voice Output: Blood can be smeared onto the test-strip pad, a hanging drop is not required. The manufacturer offers a $125.00 rebate. Suggested retail price is $635.00. With rebate (including cassette instructions), it is $510.00. A sample cassette is offered free upon request. Contact: Home Diagnostics, Inc., 6 Industrial Way West, Eatontown, NJ 07724; telephone toll-free: 1-800-342-7226; in NJ call: (201) 542-7788.

Glucometer3 Diabetes Care System: Available February 1, 1990, a new blood glucose monitoring system from Penny Saver and Ames. Special cost $44.95, less manufacturers trade-in of $35.00; final cost after trade-in is $9.95. Other diabetes supplies and equipment are on special. Contact: Penny Saver Medical Supply, 1851 W. 52nd Avenue, Denver, CO 80221; telephone toll-free: 1-800-525-7688, in Colorado, 1-800-332-7697, or in Metro Denver area, 455-5501.

Xerox/Kurzweil Personal Reader: This instrument reads single sheets or bound documents by turning the printed word into DECtalk synthetic speech. A portable optical scanner that interfaces with other computer hardware, plus it is "compatible with...Braille conversion software packages". Contact: Xerox/Kurzweil Personal Reader, Personal Reader Department, 185 Albany Street, Cambridge, MA 02139; telephone toll free: 1-800-343-0311, or in Massachusetts, (617) 864-4186.

From the Librarian

Our Diabetics Division librarian, Cheryl McCaslin, writes to tell us what is available, concerning all aspects of diabetes on cassette and in print.

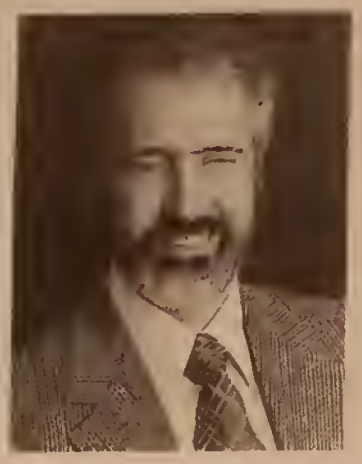
Cassettes are recorded with permission, from literature supplied by

(Continued on page 19)

Leaders of the NFB Diabetics Division

Board Members

President, Karen Mayry, 919 Main St., Suite 15, Rapid City, SD 57701; phone: (605) 348-8418.



First Vice President/Editor, Ed Bryant, 811 Cherry St., Suite 306, Columbia, MO 65201; phone: (314) 875-8911.

Second Vice President, Susan Manchester, 15 Pine Tree Lane, Apt. 1A, Fairfield, CT 06430; phone: (203) 333-1365.

Treasurer, Bill Parker, 857 Ingleside Road, Norfolk, VA 23502; office: (804) 683-8003 or home: (804) 455-6013.

Secretary, Janet Williams, 3389 Bell Avenue, Elko, NV 89801; phone: (702) 738-6920.

Committees: Chairmen and Chairwomen

Dorothy Weaver, NFB Diabetics Division, Amputations and Prevention Chairwoman.

Royanne R. Hollins, NFB Diabetics Division, Insulin Pump Chairwoman.

Linda Bingham, NFB Diabetics Division, Pancreas Chairwoman.

Cheryl McCaslin, NFB Diabetics Division, Resource Library Chairwoman.

Annie Weems, NFB Diabetics Division, Resources (Aids and Appliances) Chairwoman.

Amputation and Prevention:
Ken Carstens, 603 13th Street N., Virginia, MN 55792; phone: (218) 741-0312.

Amputation and Prevention:
Dorothy Weaver, 5679-104 Columbia Road, Columbia, MD 21044; phone: (301) 730-7543.

Renal Failure, Dialysis and Transplantation:
Karen Mayry and Ed Bryant

Get Well Committee:
Ed Bryant

Insulin Pump:
Royanne R. Hollins, 3042 La Rue Way, Rancho Cordova, CA 95670; office phone: (916) 929-9271 or home phone: (916) 369-6524.

Legislative:
Susan Manchester

Magazine:
Ed Bryant

Pancreas:
Linda Bingham, 7146 River Road, Cincinnati, OH 45233; phone: (513) 941-1193.

Resource Library:
Cheryl McCaslin, 3115 Crestview, Apt. 107, Dallas, TX 75235; phone: (214) 528-8107.

Resources (Aids and Appliances):
Annie Weems, 20820 Kenosha, Oak Park, MI 48237; phone: (313) 968-8825.

Sexual Dysfunction—Male Impotence:
Bill Parker

NFB Diabetics Division State Representatives

California:
Donna Siebert, 6213 Longmont Way, Carmichael, CA 95608; phone: (916) 965-4772.

Donovan Cooper, 421 Pass Avenue Apt. 11, Burbank, CA 91505; office phone: (213) 894-2365 or home phone: (818) 845-3141.

Connecticut:
Ray Manchester, 15 Pine Tree Lane, Apt. 1A, Fairfield, CT 06430; phone: (203) 333-1365.

Illinois:
Catherine H. Randall, 1260 West College Avenue, Jacksonville, IL 62650; phone: (217) 243-3529.

Indiana:
Betty Weston, 1608 Schuyler Ave., Lafayette, IN 47904; phone: (317) 742-5775.

Iowa:
Ron Johnson, 1229 McKinnley Drive, Ames, IA 50010; phone: (515) 232-1159.

Kansas:
Dan H. Smith, 909 North Second St., Arkansas City, KS 67005; phone: (316) 442-9159.

J.V. Watson, 21 Des Moines, South Hutchinson, KS 67505; office phone: (316) 663-8590 or home phone: (316) 465-2220.

Kentucky:
Mary Hurt, 1124 S. 1st St., Apt. 2, Louisville, KY 40203; phone: (502) 585-4457.

Massachusetts:
Gerald J. Difranza, 5 Walden St., Apt. 3-7, Wintrop, MA 02152; phone: (617) 846-7479.

Donna Dasilva Polselli, 506 College Center, 100 State St., Framingham, MA 01701; phone (617) 620-0071.

Michigan:
Beverly Helmboldt, 28068 Van Dyke, Apt. 068, Warren, MI 48093; office phone: (313) 751-4350 or home phone: (313) 558-9754.

Minnesota:
Melonie Kolaas, 2404 23rd N.W., Rochester, MN 55901; phone: (507) 281-2687.

Nevada:
Jerice N. West, 1620 Cresthaven Ave., Las Vegas, NV 89108; phone: (702) 647-0288.

New Hampshire:
Mildred Dickey, RF2 Box 1196, Meredith, NH 03253-9622; phone: (603) 279-8053.

New York:
Lorraine Webb, 315 Fay Road, Syracuse, NY 13219; phone: (315) 468-2856.

Gisela Distel, 401 2nd Ave., Albany, NY 12209; office phone: (518) 473-1728 or home phone: (518) 463-4810.

Oklahoma:
Alice Davis, 6065 East 55th Street, Tulsa, OK 74135; phone: (918) 665-2398.

Oregon:
Fred Gauble, 1969 N.W. Johnson, Apt. 502, Portland, OR 97209; phone: (503) 222-3717.

Pennsylvania:
Al Thomas, 1610 Sandusky Court, Apt. 273, Pittsburgh, PA 15212; phone: (412) 323-9045.

Tennessee:
June A. Grant, 4830 Woodland Circle, Hixson, TN 37343; phone: (615) 875-5191.

Wisconsin:
Kathline Sullivan, 1016 Jackson St., Apt. 1, La Crosse, WI 54601; phone: (608) 784-2343.

What You Always Wanted to Know

(Continued from page 17)

the Kentucky Diabetes Foundation. Titles include: High and Low Blood Sugar; Meal Planning; Healthy Hygiene; Urine Testing; Nutritional Care for Diabetes Mellitus; Personal Care Record with Food Diary; Diabetes Mellitus; Nutrition Guide; and Insulin Facts.

Cassettes cost $1.00 each. Please make tax-deductible checks payable to the National Federation of the Blind. Send orders to Cheryl McCaslin, 3115 Crestview, Apt. 107, Dallas, TX 75235; telephone: (214) 518-8107.

Our librarian reports that she has considerable print literature covering all aspects of diabetes. Several articles are available in the following categories: Diabetic Disorders; Diabetes — general information; Diabetes in Men; Diabetes in Women; Insulin; Neuropathy; Retinopathy; Transplants — Kidney and Pancreas; Beating Diabetes; Flying Solo — Managing Diabetes Alone; and Self-management for Independence. This information may be ordered at the address shown above.

Cheryl asks that one and all send articles about diabetes. She also wants everyone to know that she looks forward to seeing each of us at the 1990 annual convention of the NFB in Dallas, Texas. Cheryl has many friends who also look forward to seeing her in Dallas.

Literature

Fast Food Facts, by Marion J. Franz, R.D., M.S.. This book lists nutritive food values for several fast food restaurants and is recommended for the conscientious diabetic, as it can help in making judicious food choices. Cost: $3.95 plus $2.00 handling; contact publisher: Diabetes Center Inc., Wayzana, MN 55391; telephone toll-free: 1-800-848-2793.

Carbohydrate and Sodium-Controlled Recipes, (for Diabetic Hemo and PD Patients), by Council on Renal Nutrition/Northern California/Nevada, (spiral bound 6x9, 40 pp.). This book was listed in the March, 1989 issue of **Common Concerns,** which provides information for kidney patients and their families. Cost: $5; order from: El Camino Dialysis Services, 2500 Grant Road, Mountain View, CA 94039.

(**Editor's Note:** I have reviewed the following two books published by Surrey Books and recommend them for purchase. The recipes sound delicious but more importantly, with good judgment, we diabetics can partake and still keep our diabetes under control. Each book contains more than 150 sugar-free recipes. All recipes contain calorie counts and food exchanges per serving, and most are low-fat, low cholesterol, and low salt.)

The Free and Equal Cookbook, by Carole Kruppa, contains recipes for everything from appetizers and soups to entrees and drinks. All milk is skim and no butter is used. Cost: $9.50 (includes postage and handling); for ordering instructions see below.

The Free and Equal Sweet Tooth Cookbook, by Carole Kruppa, "is devoted entirely to recipes for snacks, desserts, and treats, including puddings, pies, and cookies." Cost: $9.50 (includes postage and handling); order from: Surrey Books, 101 East Erie Street, Suite 900, Chicago, IL 60611; telephone: (312) 751-7330.

Tidbits and Humor

Spread the Word

If you know someone who may be interested in reviewing **Voice of the Diabetic,** ask and we will send him or her a complimentary print or cassette copy (tapes recorded at 15/16 IPS). Contact: The **Voice** at 811 Cherry Street, Suite 306, Columbia, MO 65201; telephone: (314) 875-8911.

Commitment

Are you an active member? The kind that would be missed or are you content that your name is on the list? Do you attend meetings and mingle with the flock, or do you stay at home to criticize and knock? Do you take an active part to help the work along, or are you satisfied to be the kind that just belongs? Do you ever go to visit a member who is sick, or leave the work to just a few and talk about the clique? Think this over. You know right from wrong. Are you an active member, or do you just belong?

For Sale

DiaScan SVM Blood Glucose Monitoring System with voice output, includes lancing device and carrying case. This unit is brand new and has never been used. Sale price $350.00, includes shipping. Contact Kathy Marburger, 7546 Troost, Suite 213, Kansas City, MO 64131; phone: (816) 361-4462.

Thanks

We appreciate everyone who helps our Diabetics Division by distributing copies of **Voice of the Diabetic.** One of our best workers has asked that anyone in the Detroit, Michigan area, wanting a free copy of the **Voice,** contact him: Eugene Payne, 13423 Kilbourne, Detroit, MI 48213; phone: (313) 526-8619. Thanks, Eugene — keep up the good work!

Tape Players

When people become blind they usually need to use alternative techniques to keep up with printed literature. These people can receive a free cassette tape player, from the Library of Congress, which runs at standard (1 7/8 ips) or half speed (15/16 ips). Library of Congress tapes, as well as the cassette version of **Voice of the Diabetic,** run at half speed, so a special player like this is needed.

Tape players may be ordered from your regional Library for the Blind and Physically Handicapped; to locate it phone the Library of Congress toll-free at 1-800-424-8567. These tape players are mailed as Free Matter for the Blind.

Display Tables

This year's annual convention of the NFB will take place in Dallas, Texas, and at this momentous event our Diabetics Division has reserved space in the exhibit hall.

There will be hundreds of display tables with products and information that may be of interest to blind persons.

Our Diabetics Division will display literature and equipment that will be of interest to blind diabetics or to any person with diabetes.

CAN YOU HELP? It takes many people to work our display tables, and if you can help for two hours, four hours, or more, please contact our display table chairman: Bill Parker, 857 Ingleside Road, Norfolk, VA 23502; phone: (804) 623-1638.

New Book

Take Charge: A Strategic Guide for Blind Job Seekers
By: Rami Rabby and Diane Croft
Published by National Braille Press, Inc., 1989

This book has been described by the publisher as "...a practical self-help guide built upon the real-life experiences of blind people. The book is anchored in reality. It proposes strategies for dealing with a resistant labor market, and assists blind job seekers in unraveling the complexities of the labor market and of life in the workplace; analyzing jobs; focusing on one's true career interests and work-related skills; networking one's way to the personal attention of a hiring manager; probing an interviewer's state of mind and conclusions about one's candidacy; and strategizing one's way out of frustrating work situations."

As editor of the **Voice** I have not, as of yet, reviewed this book; but I have read several reviews praising *Take Charge.* Rami Rabby, who is blind, is a consultant on employment of the disabled. He has a B.A. degree from Oxford University, England, and a master's degree in Business Administration from the University of Chicago. The strategies he suggests in this book result from his long experience as a personnel and training professional in business and industry. I recommend that all blind job seekers, or diabetics just starting to lose vision, consider purchasing this book.

(Continued on page 20)

Tidbits and Humor

(Continued from page 19)

Order from: National Braille Press, Inc.; 88 St. Stephens Street; Boston, MA 02115; phone: (617) 266-6160. Cost: $19.95 for five-volume Braille edition (shipped Free Matter, add $4 for UPS); $19.95 for two, four-track cassette edition (shipped Free Matter, add $4 for UPS); $23.95 for 350-page paperback edition (includes UPS shipping).

NFB Scholarship Program

With more than 50,000 members, the National Federation of the Blind (NFB) is the largest organization of blind citizens in existence. The NFB awards far more in scholarships than any other group or organization. In 1990 the NFB will commemorate its 50th anniversary, and $71,000 will be awarded in scholarships. There are 26 scholarships offered, ranging from $2,000 - 10,000. In addition to scholarships, total expenses will be paid for recipients to attend the annual convention of the NFB to be held this year in Dallas, Texas.

All scholarships are merit-based, and most are unrestricted. Basic eligibility requires the applicant to be legally blind and a full-time student in the Fall of 1990. Criteria by which entries will be judged are academic excellence, financial need, and service to the community. The committee which evaluates and chooses scholarship winners is composed of blind citizens from across the country, with distinguished community and academic backgrounds.

The National Federation of the Blind is an organization dedicated to creating opportunity for all blind persons. Recipients of Federation scholarships need not be members of the National Federation of the Blind.

In the past, we have received approximately 500 scholarship applications each year. Applications must be received by March 31, 1990. Anyone interested may request and receive as many application forms as desired from:

National Federation of the Blind Scholarship Committee Chairwoman, Peggy Pinder; 814 4th Avenue, Suite 200; Grinnell, Iowa 50112; (515) 736-3366.

The National Center for the Blind, Scholarship Committee; 1800 Johnson St.; Baltimore, MD 21230; (301) 659-9314. Or all NFB affiliate presidents.

The NFB Scholarship program for blind students is great. Remember applications must be received by March 31, 1990, so get your applications in!

*The following appeared Summer, 1989 in the **Viewfinder**, the newsletter of the NFB of Rhode Island:*

Thought

Thought is subversive and revolutionary, destructive and terrible. Thought is merciless to privilege, established institutions, and comfortable habit. Thought looks into the pit of Hell and is not afraid. Thought is great, and swift and free, the light of the world and the chief glory of man.
—Selected Papers of Bertrand Russell

Q. Why is it that there was no poker-playing on Noah's ark?
A. Because Noah was always standing on the deck.

Thinking is the hardest work there is, which is the probable reason why so few engage in it. —Henry Ford

Q. What day of the year is a command?
A. March 4th.

ADVERTISERS

Effective advertising doesn't scream at its audience. It persuades. It sells. The key to cost-effective advertising is making your voice heard where an audience is already listening. *Voice of the Diabetic* offers such an outlet. Make *your* voice heard. For advertising information contact:

Voice of the Diabetic
Ed Bryant, Editor
811 Cherry Street, Suite 306
Columbia, MO 65201
(314) 875-8911

A Bargain

—from the Editor

*The **Voice of the Diabetic** has enjoyed a prolific growth rate. The first issue was in January, 1986, with a circulation of about 600. Today, four years later, the circulation is more than 35,000.*

Until this edition, we have asked for a yearly membership fee of $2.00 for people wanting to be members of the Diabetics Division of the NFB, and an $8.00 yearly subscription fee for institutions, professionals, and non-members.

*We have been able to offer the **Voice** at those prices because the entire board and all leaders of our NFB Diabetics Division work as volunteers. We also receive donations which help keep our magazine afloat. Plus, we have begun accepting advertisements.*

*All other large publications dealing with diabetes realize a profit, while **Voice of the Diabetic** was not set up to be profitable. Instead, our publication is intended to dessiminate information and extend a helping hand to provide support. To anyone wanting to receive the **Voice** but unable to pay, we provide a complimentary subscription.*

*In 1989, due to the **Voice's** popularity and so many people and institutions, interested in all aspects of blindness and diabetes, wanting to be on our mailing list, our operating budget ended up in the red. So, effective immediately, our NFB Diabetics Division has raised its yearly membership dues to $5.00, which includes a free subscription to **Voice of the Diabetic**. For institutions, professionals, and non-members the subscription fee is now $15 for one year, $28 for two years, or $40 for three years.*

Of course, your old membership or subscription rate continues until expiration; you will be reminded of the increase with your renewal notice.

I think it is obvious that our new pricing policy is extremely reasonable, in fact a bargain. But even with our price increase we must spend judiciously to be in the black for calendar year 1990.

All donations are tax deductible, and they are needed. I speak for all leaders of our NFB Diabetics Division when I say, "Thank you for your support!" Please make checks payable to **National Federation of the Blind** *and send to **Voice of the Diabetic**, 811 Cherry St., Suite 306, Columbia, MO 65201; phone: (314) 875-8911.*

Subscription/Donation/Membership Form

Voice of the Diabetic is a quarterly magazine for anyone interested in diabetes, especially diabetics who are blind or losing vision. The $5.00 annual membership fee of the Diabetics Division of the National Federation of the Blind (NFB) entitles you to a year's subscription to **Voice of the Diabetic**. However, production cost per annual subscription of the **Voice** is about $15.00, and for this reason we must charge all non-members, health professionals and institutions $15.00 for an annual subscription. Of course, all donations are accepted and very much appreciated.

You may receive the *Voice* as a member or non-member. ***Please check one:***

☐ I would like to become a member of the Diabetics Division of the NFB and receive a free subscription (one year) to *Voice of the Diabetic:* ($5.00)

☐ I would like to subscribe to *Voice of the Diabetic* as a non-member, health professional, or institution. ($15.00/one year; $28.00/two years; $40.00/three years)

The *Voice* is available in print or on half-speed (15/16 ips) cassette tape; cassettes are provided at no extra cost. ***Please check one box.*** I would like to receive *Voice of the Diabetic:*

☐ in print ☐ on cassette tape ☐ both in print and on cassette tape

Optionally, check this box:

☐ I would like to make (or add) a tax-deductible contribution of $_____ to the Diabetics Division of the NFB.

Please print clearly

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number (_____) _____

Send this form or a facsimile along with your check to our editor:

Ed Bryant, 811 Cherry St., Suite 306, Columbia, MO 65201

Please make all checks payable to the **NATIONAL FEDERATION OF THE BLIND.**